Intraethnic, intra-cultural variations and similarities among "Hispanics" in the USA: implications for patient compliance and health care provider education.

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INTRAETHNIC, INTRA-CULTURAL VARIATIONS AND SIMILARITIES AMONG "HISPANICS" IN THE USA: IMPLICATIONS FOR PATIENT COMPLIANCE AND HEALTH CARE PROVIDER EDUCATION

A Dissertation Presented
By
Lourdes Coello Delson

Submitted to the Graduate School of the University of Massachusetts in partial fulfillment of the requirements for the degree of DOCTOR IN EDUCATION

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Education
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In loving memory of my father,
Dr. Miguel A. Coello, whose
integrity, compassion and
ethics I cherish.

In honor of my mother, Mrs.
Margarita Cueva Chavarry de
Coello, devoted teacher and
dear friend.

To my husband, Dr. Abe Delson,
my source of strength, who encour-
aged me to finish this dissertation,
by assuring me that nobody (besides
the Members of my Committee) would
read it, and gave me the courage
to complete it.

To Miss Margaret Hogan, former
Nursing Director of Wesson Women's
Hospital in Springfield, Massa-
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professional, whose sensitivity
and commitment to patient health
care has inspired this work.
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ABSTRACT

INTRAETHNIC, INTRA-CULTURAL VARIATIONS AND SIMILARITIES AMONG "HISPANICS" IN THE USA: IMPLICATIONS FOR PATIENT COMPLIANCE AND HEALTH CARE PROVIDER EDUCATION

May 1985

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This work has been prompted by the cultural and linguistic conflicts observed among Hispanic patients/clients--mostly monolingual, poor Puerto Ricans--and many well-meaning but culturally illiterate, hard-working Anglo health care providers in Western Massachusetts during more than fifteen years as a health worker.

Although there are about 20 million Hispanics in the United States--which constitute the second largest minority--there is a paucity of valid, well-researched, culturally relevant health studies. Mexican Americans, Puerto Ricans, Cuban-Americans, South Americans, and other Latin American sub-groups are homogenized as a monolithic group, without regard for differences in socioeconomic status, rurality/urbanity, and generation levels in the USA, degree of acculturation and bilingualism, politico-historical background, and education. Besides, bizarre health behaviors
are ascribed to the group, particularly regarding compliance.

Compliance, or Patient Compliance, is a well-known issue in the health field attested by the vast current literature. It may be simply defined as "following the health care provider's instructions." The studies and research reveal more than three hundred factors responsible for non-compliance--the opposite of compliance and the focus of most health investigations. Factors such as language, culture, ethnicity, social class, education, rurality/urbanity, income, illiteracy, modesty, anxiety, and cost are common to both non-compliance and the barriers to quality care among all patients in general and Hispanics in particular.

The purpose of this work is to foster better health care for Hispanic patients--specially Puerto Ricans in Western Massachusetts--by sensitizing health care providers to the backgrounds and problems of their Hispanic patients. Through the vehicle of compliance it is possible to facilitate communication, improve the patient provider interaction, and avoid generalizations and stereotyping. A discussion of intraethnic, intracultural variations and similarities among Hispanics in the United States will follow a review of the literature on compliance, with special emphasis on the role of class, so deterring to health care, and on the role of the Hispanic family and its influence on the health
values, beliefs and practices of its members.

Because the majority of Spanish-speakers individuals in most health settings of Western Massachusetts are often poor, young and monolingual Puerto Ricans or of Puerto Rican heritage, emphasis is centered on this group. The barriers to health mentioned in the literature, such as social class, language, culture, color, education, income, migration, and ethnicity have been discussed with particular emphasis on the role of acculturation. These factors will be considered in reviewing some health practices, beliefs and attitudes of Puerto Ricans in the mainland, particularly two ethnic disorders.

At the invitation of Wesson Women's Unit of Baystate Medical Center in Springfield, Massachusetts, a group of thirty-five pregnant Puerto Rican women and their appointment-keeping behaviors were investigated. A bilingual (Spanish/English) Questionnaire was developed classifying variables into three groups: demographic, environmental/structural, and personal characteristics of the participants. This part of the dissertation entitled, "A Descriptive Study of Compliance Among Pregnant Puerto Rican Women at Baystate Medical Center in Springfield, Massachusetts," may increase the Anglo health care providers' understanding of apparent non-compliance. By investigating factors affecting compliance in a local health setting, program changes may be accomplished.
Due to the descriptive nature of the study and its limitations because of its size and the focus on non-compliance, the findings may not be generalized to the whole Puerto Rican community. However, future studies involving larger samples may find value in the variables selected and the methodology and data analysis. Also, it is hoped that because of this study, changes in practices of health care delivery at Wesson Women's Unit will occur which will make it easier for other pregnant Puerto Rican women to keep their appointments and for Anglo health care providers to be sensitized to the plight of their Puerto Rican patients.

Hopefully, this dissertation will encourage further research and health studies focused on local health needs of Puerto Ricans. By stressing the importance of intra-ethnic, intracultural variations and similarities among the various Hispanic sub-groups in the United States better compliance, health care provider education, and quality health care may be fostered.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Background of the Problem</td>
<td>1</td>
</tr>
<tr>
<td>Statement of Purpose</td>
<td>5</td>
</tr>
<tr>
<td>Specific Aim</td>
<td>10</td>
</tr>
<tr>
<td>Significance</td>
<td>10</td>
</tr>
<tr>
<td>Methodology</td>
<td>10</td>
</tr>
<tr>
<td>Rationale and Significance of the Study</td>
<td>12</td>
</tr>
<tr>
<td>Limitations of the Study</td>
<td>13</td>
</tr>
<tr>
<td>Outline of the Dissertation</td>
<td>16</td>
</tr>
<tr>
<td>Operational Definitions</td>
<td>18</td>
</tr>
</tbody>
</table>

| II. COMPLIANCE | 20 |
| Definitions | 20 |
| Extent of the Problem of Non-Compliance | 23 |
| Factors Affecting Compliance/Non-Compliance | 26 |
| The Patient Provider Interaction | 31 |
| The Health Provider | 47 |
The Patient .................................................. 56
Immigration in the United States ..................... 65

III. HISPANICS IN THE UNITED STATES ................. 71
Definitions of "Hispanic" ................................. 73
Identification of Hispanics as an Ethnic Group ....... 74
Diversity Among Hispanics in the USA ............... 76
Migration and Immigration of Hispanics ............... 79
Factors Affecting Health ................................. 83
   Rurality/Urbanity ....................................... 83
   Age of Hispanics in the USA .......................... 83
   Fertility .................................................. 84
   Education ............................................... 85
   Income of Hispanics .................................... 89
   Language ............................................... 91
   Culture ............................................... 94
   Ethnicity .............................................. 100
   Social Class .......................................... 102
   Literacy/Illiteracy .................................... 106
The Hispanic Family and its Influence on Health Beliefs Practices ................................. 109
   The Hot and Cold Theory .............................. 115

IV. PUERTO RICANS IN THE MAINLAND AND THE ISLAND 117
Introduction ............................................. 117
Geographic and Historical Background of Puerto Rico ................................................. 118
VI. CONCLUSIONS AND STRATEGIES

SELECTED BIBLIOGRAPHY

APPENDICES

A. English and Spanish Questionnaires

B. Proposal - A Descriptive Study of Compliance Among Pregnant Puerto Rican Women at Baystate Medical Center in Springfield, Massachusetts

C. Baystate Medical Center - Protocol

D. Consent Form - English and Spanish

E. Follow-up Letter - Spanish

F. Suzuki's Ethnic/Cultural Background Exercise
## LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Language Preferred for Interview</td>
</tr>
<tr>
<td>2</td>
<td>Birthplace</td>
</tr>
<tr>
<td>3</td>
<td>Self-Identification</td>
</tr>
<tr>
<td>4</td>
<td>Age</td>
</tr>
<tr>
<td>5</td>
<td>Marital Status</td>
</tr>
<tr>
<td>6</td>
<td>Trimester of Entry</td>
</tr>
<tr>
<td>7</td>
<td>Time Living in Springfield</td>
</tr>
<tr>
<td>8</td>
<td>Where Did You Attend School?</td>
</tr>
<tr>
<td>9</td>
<td>Years of Education</td>
</tr>
<tr>
<td>10</td>
<td>Occupation</td>
</tr>
<tr>
<td>11</td>
<td>Distance to Clinic</td>
</tr>
<tr>
<td>12</td>
<td>Type of Transportation Used</td>
</tr>
<tr>
<td>13</td>
<td>Difficulty in Getting to Clinic</td>
</tr>
<tr>
<td>14</td>
<td>Satisfaction with Care</td>
</tr>
<tr>
<td>15</td>
<td>Waiting time at Clinic</td>
</tr>
<tr>
<td>16</td>
<td>Conflicts with Clinic Appointments</td>
</tr>
<tr>
<td>17</td>
<td>Sex of Physician Preferred</td>
</tr>
<tr>
<td>18</td>
<td>Sex of Examining Physician</td>
</tr>
<tr>
<td>19</td>
<td>Clarity of Instructions</td>
</tr>
<tr>
<td>20</td>
<td>Who Explains Instructions?</td>
</tr>
<tr>
<td>21</td>
<td>Awareness of Appt. and Procedures</td>
</tr>
<tr>
<td>22</td>
<td>Readibility of Printed Materials</td>
</tr>
<tr>
<td>23</td>
<td>Who Helps You Decide on Health?</td>
</tr>
<tr>
<td>24</td>
<td>Who Suggested Wesson Clinic?</td>
</tr>
<tr>
<td>Table</td>
<td>Page</td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>25</td>
<td>Number of Children Living with You/Responsible for</td>
</tr>
<tr>
<td>26</td>
<td>Children up to Five Years Old Living with Patient</td>
</tr>
<tr>
<td>27</td>
<td>Childcare Arrang. Problems?</td>
</tr>
<tr>
<td>28</td>
<td>In What Language do You Prefer to Read?</td>
</tr>
<tr>
<td>29</td>
<td>Read English?</td>
</tr>
<tr>
<td>30</td>
<td>Understand What You Read in English?</td>
</tr>
<tr>
<td>31</td>
<td>Write in English?</td>
</tr>
<tr>
<td>32</td>
<td>Read Spanish?</td>
</tr>
<tr>
<td>33</td>
<td>Understand What You Read in Spanish?</td>
</tr>
<tr>
<td>34</td>
<td>Write in Spanish?</td>
</tr>
<tr>
<td>35</td>
<td>Reasons for Noncompliance</td>
</tr>
<tr>
<td>36</td>
<td>Methods to Record Appts.</td>
</tr>
<tr>
<td>37</td>
<td>Do You use Appointment Cards?</td>
</tr>
<tr>
<td>38</td>
<td>Beliefs in Hot/Cold Theory?</td>
</tr>
<tr>
<td>39</td>
<td>Hot/Cold Theory Examples?</td>
</tr>
<tr>
<td>Chart</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>Language Preferred for Interview</td>
</tr>
<tr>
<td>2</td>
<td>Birth Place</td>
</tr>
<tr>
<td>3</td>
<td>Self-Identification</td>
</tr>
<tr>
<td>4</td>
<td>Age</td>
</tr>
<tr>
<td>5</td>
<td>Marital Status</td>
</tr>
<tr>
<td>6</td>
<td>Trimester of Entry</td>
</tr>
<tr>
<td>7</td>
<td>Time Living in Springfield</td>
</tr>
<tr>
<td>8</td>
<td>Years of Education</td>
</tr>
<tr>
<td>9</td>
<td>Distance to Clinic</td>
</tr>
<tr>
<td>10</td>
<td>Type of Transportation Used</td>
</tr>
<tr>
<td>11</td>
<td>Difficulty in Getting to Clinic</td>
</tr>
<tr>
<td>12</td>
<td>Satisfaction with Care</td>
</tr>
<tr>
<td>13</td>
<td>Who Explains Instructions?</td>
</tr>
<tr>
<td>14</td>
<td>Awareness of Appt. and Procedures?</td>
</tr>
<tr>
<td>15</td>
<td>Readability of Materials</td>
</tr>
<tr>
<td>16</td>
<td>Number of Children Living with You/ Responsible for</td>
</tr>
<tr>
<td>17</td>
<td>Children up to Five Years Old Living with Parents</td>
</tr>
<tr>
<td>18</td>
<td>In What Language do You Prefer to Read?</td>
</tr>
<tr>
<td>19</td>
<td>Reasons for Noncompliance</td>
</tr>
</tbody>
</table>
CHAPTER I
INTRODUCTION

Background of the Problem

Hispanics are a heterogeneous group comprising individuals of numerous national origins. Their families may have resided in the USA for hundreds of years or only a matter of days. They may be proficient in English, proficient in Spanish, proficient in neither, or proficient in both. They share a common denominator, however: the effects of neglect by the health research community. At present we do not even know . . . their health status, use of services, or unmet health care needs.

(Treviño, 1982: 979)

Hispanics in the United States constitute the second largest minority (estimated to be over twenty million individuals) whose diverse ethnic, cultural, linguistic, racial, historico-political, religious, educational, and socioeconomic backgrounds are being ignored and confused in health research.

Mexican Americans, Puerto Ricans, Cuban-Americans, and other Latin American sub-groups—which comprise the Hispanic group—are lumped together and homogenized into a monolithic, stereotyped, and colorful mass, with attributed primitive and bizarre health attitudes, beliefs and practices. A great number of current health studies and surveys generated to develop health programs for Hispanics in the different American communities are tainted by faulty methodology because nearly all assume an alleged homogeneity binding all Hispanics.
Different criteria and terminology are being used throughout the United States to identify, include, and exclude individuals of Spanish ancestry. There is no operationalized or standardized definition for "Hispanic." Some surveys have used a Spanish surname criterion, others have chosen Spanish origin, surname of head of household, origin of the mother, birthplace of parents or self, use of the Spanish language at home, appearance of the interviewed individual, and self-identification. Possession of any one of these criteria has been sufficient for inclusion in the surveys as a "Hispanic." Naturally, there have been problems and confusions because of the exclusion of Hispanics with non-Hispanics names (such as that of the author's), inclusion of non-Hispanics with Spanish surnames, differences in self-reporting varying with respondents' own perceptions of their origins, and, even worse, misclassifications of individuals because of interviewers' biased observations.

The contamination of data and faulty statistics result in distortion of important information for health purposes, causing loss of funds, benefits and privileges, legal complications with eligibility of services, problems with affirmative action benefits, and serious census-undercounts (Hayes-Bautista, 1980).

For census purposes the population of the United States has been classified into three major racial groups: White, Black/Negro, and Other. Hispanics have been traditionally
classified as White—"White Persons of Spanish Surname."

Data obtained for the 1960 and 1970 censuses specified that:

\[\text{...persons who did not classify themselves in one of the specified race categories, but entered Mexican, Puerto Rican, or a response suggesting Indo-European stock, were classified as White.}\]

(1980 Census: 3)

The problem with that classification is that Hispanics are then counted as part of the general white population, with consequent losses of funds, allocations, and other benefits.

In other surveys, Hispanics are grouped together with other "minorities" and it is impossible to separate the Hispanic group or, even worse, subgroups such as Puerto Ricans.

Added to the problems in terminology, gathering of data, and methodology is a disregard of differences among Hispanics in education, acculturation, degree of bilingualism, socioeconomic status, geographic location—whether rural or urban—of individuals selected in health care studies (Aday, Chiu and Andersen: 1980; Canino and Canino: 1981; Chesney, Chavira, Hall and Gary: 1982; Mizio: 1977; Quesada: 1976; Rodriguez: 1983; Roberts and Lee: 1980; Saunders: 1954; Saylor: 1977; Treviño: 1982). In other words, intraethnic, intracultural variations and similarities among Hispanics in the United States are being disregarded in health studies.

The media have also contributed to the distortion and stereotyping of Hispanics in the United States. It often presents a lazy, monosyllabic Pedro Gonzalez or Pepe Taco
who answers most questions in a disconcerting, nasal "sí."
This black mustachioed cartoon-like character sleeps constantly
under a wide-brim Mexican hat, waking up sporadically to
shoot anything that moves around him, happily returning
to his "siesta"—aided by a shot of tequila or rum. There is
a "señorita" at his side. She wears a peculiar Carmen Miranda-
type turban, a cornucopia of various tropical fruits, balanced
miraculously on her head, while she frantically dances to
the rhythms of a chaotic mixture of a tango-rumba-bolero-
pasodoble-chachacha-flamenco tune, played by guitars, maracas,
castanets, marimbas, and drums. . . Ah, yes! The lady wears
a tightly fitted red satin dress or a ruffled polychromatic
outfit, while chanting a litany of fast, strange incantations
that are supposed to be utterances in the Spanish language!

In the case of Puerto Ricans, the distortions and
stereotyping are complicated by the current socioeconomic,
political, cultural, and linguistic problems faced by many
poor Puerto Ricans on the mainland—the United States. There
is a paucity of valid, up-to-date health studies, particularly
in Springfield, Massachusetts. It is not a conspiracy of
silence on the part of health researchers but rather a result
of faulty terminology and methodology employed in health
programs. It is imperative that local research be undertaken
in order to understand and truly meet the health needs of
Puerto Ricans—particularly the poor—who constitute the
largest Hispanic subgroup in this area of Massachusetts.
II. Statement of Purpose:

In order to foster better health care for Hispanics—particularly the Puerto Rican monolingual poor in Western Massachusetts—there is a need to sensitize Anglo health care providers to the multifactorial nature of the health problems affecting their patients/clients and their families. Therefore, I will be conducting a research on pregnant Puerto Rican women seeking prenatal care at a local hospital. That will be the practical portion of this dissertation. The other segments will deal with issues involving Hispanics in the United States—with emphasis on Puerto Ricans. Definitions of terms necessary for the understanding of intraethnic, intracultural variations and similarities among Hispanic subgroups will be supplied. The universality of non-compliance will be discussed, with the hope of using this extensive body of literature to sensitize Anglo health providers.

"Compliance," also known as "patient compliance," "adherence," and "patient cooperation" may be defined as "following the health care providers's instructions as to diet, exercise, rest, medications, schedules, and other lifestyle changes." This is a very complex and critical issue in the health field, attested by the numerous and controversial research studies, workshops, and publications in the United States and abroad. Its opposite, "non-compliance," is actually the focus of the practical part of my research, entitled "A Descriptive Study of Compliance Among Pregnant
Puerto Rican Women at Baystate Medical Center in Springfield, Massachusetts."

For the past fifteen years--while working as a bilingual health educator, Instructor of Medical/Cultural Spanish at a metropolitan community college, hospital volunteer, clinic interpreter, bilingual secretary, and older college student--I have been concerned with problems of compliance. I have witnessed the alienation, suffering and pain of many Hispanic patients--mostly monolingual, low-income Puerto Ricans--and the frustrations of hard-working, well-meaning Anglo health care providers. Often many of these health workers know very little about their patients' backgrounds. Some of these professionals seem to have forgotten their own ethnic and family roots--a case of "ethnic amnesia" and "cultural illiteracy" (Suzuki, 1982).

During my work at the hospital as an interpreter and later as the teacher of Medical Spanish, I would be asked frequently to explain some "peculiarities" and idiosyncrasies of the Puerto Rican patients which were baffling to the volunteers and staff. Often the conflicts were caused by cultural and linguistic barriers between the Spanish-speaking patients and the Anglo health care providers. Jean Ablon (1981) has described these behaviors as those of "stigmatized patients" who

... may exhibit diverse cultural beliefs and linguistic and 'compliance' patterns which early on serve to alienate them from care providers. (p. 7)
Often questions were: "Why don't they take their pills and medications?"; "Why do they wait till they are six or seven months pregnant to come to the clinic for their first visit?"; "Why don't they keep their appointments?"; "Why do they keep using the emergency rooms instead of coming to the clinics?"; "Why do they insist in meeting the doctors at the examining rooms fully clothed, while burying their heads under the covers? After all, some of them are mothers of four or five kids!"; "Why do they all have such long, double names?"; "WHY, OH, WHY CAN'T THEY LEARN ENGLISH?"

Thanks to the vision and commitment of the Nursing Director, I was able to develop a mini-course in medical Spanish that was offered to the hospital staff and volunteers. We also developed culturally relevant audiovisual materials. I remember being asked to translate a tape entitled, "The Baby's Bath." One of the instructions was to "hold the baby in a football position. . ." (circling the baby's body with one arm resting against the hip). I explained to the staff that I couldn't translate those instructions since "a football position" in Latin America would mean that the baby had to be placed on the floor! (Soccer is call "football" in Latin America.) What would the Hispanic mothers think of Anglo health providers who asked them to put the baby on the floor, like a ball, to give him/her a bath! The staff and I shared a good laugh and decided that more discussions on cultural differences and similarities were urgently needed
in the health field. Therefore, a second minicourse followed. At the end of the second mini-course I knew I had to go back to college and get more training in health, culture and language.

Health education courses led to patient education—activating the patient to become responsible for his/her own health. Knowledge of the Spanish language and culture became a powerful public health tool. The theme of compliance became a critical issue for my future work. I developed and taught a course entitled "Medical Spanish"—which was later to be renamed "Cultural Spanish"—to allied health and nursing students at a local community college. It was then I decided to seek a doctorate in multicultural education.

I am now privileged to present my research dealing with intraethnic, intracultural variations and similarities among Hispanics in the United States, with emphasis on Puerto Ricans.

The issue of social class has been stressed in this work because of its implications in health. As Knutson (1965) has stated:

Public health practitioners and researchers have need for simple measure of social class for studying the cause and course of illness, the patterns of its distribution and effects, its varying impact on different populations. Such data are needed for program planning and development and for evaluating the varying effects of program efforts.

(pp. 103-104)

The operational definition for "Anglo health care provider," "health provider," or "provider" will be extended
to every non-Hispanic, English-speaking member of the health

team: health educators, nurses, physicians, dentists, allied

health workers, social workers, medical secretaries, recep-
tionist, hospital volunteers, counselors, administrators, and

religious leaders in every health care setting.

In order to foster quality care, with provisions for
cost containment, it is important that health workers in the
United States, a multilingual, multiethnic, multicultural
country, understand the importance of a holistic approach to
health care and research, so eloquently expressed by Klein
(1979) as follows:

Perceptions of health and illness differ
from individual to individual and from
culture to culture. Differences and
similarities. . . depend on a multitude
of complex social, cultural and environ-
mental factors. . . In a pluralistic
society. . . Individuals begin to be
seen as members of various subcultures.
In addition to being ethnically identified.
also identified according to social class,
economic status, politics, religion, sex,
age, occupation. . . (the list is hardly
exhausted). . . Each category cross-cuts
the others and . . . has been correlated
with different health attitudes.

(Klein: 2, 152: 1979)

In dealing with problems of health care among Hispanics and
the issue of patient compliance, I have followed Klein's
advice to prepare my research.

I am convinced that before patient compliance may be
expected or patient education programs may be initiated, valid,
reliable, and culturally relevant local health studies must
be conducted. Therefore, what follows now is a description of a local study focusing on factors affecting compliance with scheduled appointments.

**Specific Aim**

This part, entitled "A Descriptive Study of Compliance Among Pregnant Puerto Rican Women at Baystate Medical Center, Springfield, Massachusetts," will investigate variables influencing patient compliance with prenatal and diagnostic test appointments among a sample of Puerto Rican women at Wesson Women's Unit. By focusing the investigation on variables affecting compliance among Puerto Ricans in local health settings, favorable pregnancy outcomes may be fostered.

**Significance**

By increasing the health care providers' understanding of apparent non-complying behavior, Anglo health care providers may be sensitized to the plight of Puerto Rican patients in particular and Hispanic patients in general. The benefits of the study may be changes in the methods of health care delivery which will make it easier for pregnant Puerto Rican women to keep appointments and foster favorable pregnancy outcomes.
Methodology

This study will involve 50 women currently using Wesson Women's Unit of the Baystate Medical Center for prenatal care. Structured interviews, preferably by telephone, will be conducted by the investigator using the enclosed questionnaire. If clients cannot be reached by telephone, the interviewer will see patients at the next regularly scheduled clinic appointment. Demographic information available in Continuing Care records will be utilized. Identification of target population will be made by the Supervisor of Ambulatory ob/gyn clinic and/or her staff from daily appointment lists. Names of target population will be shared only with the investigator.

The variables to be investigated include demographic, structural, and personal characteristics of the patients, as described in the attached questionnaire (English and Spanish translations).

The interview will be conducted in English or in Spanish, in accordance with the preference of the patient, stated at the beginning of the telephone conversations.

Expected duration of the study is four months (between September and December 1984), after which time the data will be analyzed and the results will be evaluated. As has been indicated in the attached Consent Form, this study will not involve any medical or experimental treatment and will not affect prenatal or postnatal care of the women involved.
Rationale and Significance of the Study

Among minority women, the risks of poor pregnancy outcomes may be doubled and even tripled by inadequate prenatal care. Compliance is considered a major tool in the prevention of problems during pregnancy. Increasing health care providers' understanding of the non-compliant patient may assist in fostering favorable pregnancy outcomes.

In an effort to search for strategies that will foster better patient care and improve communication between Puerto Rican patients and Anglo health care providers, this practical application, and the literature review on compliance, and of Hispanics in the United States, may also help in educating Puerto Rican women on the advantages of complying with providers' instructions, specially those related to appointment-keeping during pregnancy and post partum.

This study will also have the value of a fresh perspective, since it is being written by a member of the "Other" Hispanic subgroup. As will be seen in the bibliography, there is a minimal amount of studies on health care of Hispanics prepared by Other Hispanic professionals. Therefore, most of those studies present the issues from a Chicano/Mexican American or Puerto Rican perspective. This work is the research of an acculturated, but not assimilated Hispanic health worker committed to the improvement of health care for Hispanics, particularly the monolingual Puerto Rican poor in Western Massachusetts.
Limitations of the Study

The study within a study—"A Descriptive Study of Compliance Among Pregnant Puerto Rican Women at Baystate Medical Center, Springfield, Mass." will be undertaken over the phone, not face-to-face. This may seem to be a limitation. However, the investigator's experience with previous questionnaires and her knowledge of the language and the culture of the participants will be of help. Having worked at Wesson Women's as a volunteer for five years, this population of pregnant young Puerto Rican women is quite well understood by the researcher.

Another limitation of the study may be that the director of the project, Ms. Jones, will be selecting the population based on a Spanish surname. This may exclude some Hispanics and include some Anglos, as explained before. However, it will be easy to correct that deficiency by asking the initial question, "Are you a Puerto Rican?" or "Do you consider yourself a Puerto Rican?" Besides, the opening paragraph of the telephone survey (Appendix A), states that this is a study of pregnant Puerto Rican women and requests the consent of the client before attempting an interview.

Another limitation may be the number of participants—fifty women—which may not be representative of all Puerto Rican pregnant women in Springfield, since the population consists of clinic patients. On the other hand, it will represent the majority of the working poor class in need of
community and health services. Hopefully, the study may generate data of possible value to other Puerto Rican communities in the area.

A limitation of this study that is lamented is that since it deals only with non-compliant pregnant women, the data may not supply information on adolescent pregnancy among Puerto Ricans. Teenage pregnancy is interrelated with high rates of infant mortality, child abuse, school dropouts, unemployment, crime, violence, drug abuse, welfare and poverty. Since most studies mentioned in the researched bibliography indicate that the Puerto Rican population in the mainland is very young—with a median age of approximately 14.7 years in Springfield, Mass. (Spanish-American Union's statistics of 1978), it would be important to test the validity of that age claim and update the data. Also, is it true that "Hispanic"—actually Puerto Rican—women are responsible for current pregnancy rates that give Springfield the dubious honor of being the second city in the State having the highest incidence of teenage pregnancies? Although this is claimed to be true, it cannot be documented because of the limitations of this study.

What we may be able to see is how many of these pregnant women are dropouts, how many years of education they average, whether there are problems in literacy and language performance, if instructions are understood in order to be followed. More important yet will be to gather data on factors that are now
contributing to non-compliance during pregnancy and that may be preventable. Also, the responses, comments and recommendations of the pregnant women in the study may be instrumental in influencing future changes in health care delivery at Wesson Women's Unit and at other institutions. Finally, the attitudes of Anglo health care providers may reflect the sensitivity that is basic for quality care in multicultural settings.

Strategies for improving the health of Hispanics in Western Massachusetts will complete this research—in conjunction with the bibliography—as indicated in the following outline.
Outline of the Dissertation

Chapter I. Introduction

Introduction and Statement of the Problem

Purposes

General Aim
Specific Aims
Significance
Methodology
Rationale and Significance of the Study
Limitations of the Study
Operational Definitions

Chapter II. Compliance

Definitions
Types of Compliance
Factors Affecting Compliance
Review of the Literature

The Patient-Provider Interaction as the Most Important Factor in Compliance

Review of the Literature
The Health Care Provider
Review of the Literature
The Patient
Review of the Literature

Chapter III. Hispanics in the United States

Definitions
Historical Background
Social Class and Its Influence on Health
Factors Affecting Health
The Family

Chapter IV. Puerto Ricans on the Mainland and the Island
Definitions
Historical Background
Factors Affecting Health
The Family

Existing Health Data on Puerto Ricans in Springfield

Chapter V. Applying the Methodology - "A Descriptive Study of Compliance Among Pregnant Puerto Rican Women at Baystate Medical Center in Springfield, Mass."

Introduction
Assumptions
Methodology
Consent Form
Questionnaire (English and Spanish)
Data Analysis and Results
Conclusions and Recommendations

Chapter VI. Conclusions and Strategies

Bibliography
Appendices
Operational Definitions and Concepts

1. Acculturation - The process by which the members of one group adopt the customs and characteristics of another.


3. Assimilation - "The act of completely moving into a society and becoming completely like that system by giving up original characteristics and values and taking those of the new society." (Saylor)

4. Compliance/Patient Compliance - "The extent to which a person's behavior--taking medication, following diets, or executing other lifestyle changes--conforms to medical or health advice." (Bruer)

5. Culture - "In anthropology, the way of life of a society... The customs, ideas and attitudes shared by a group... transmitted from generation to generation by learning processes rather than biological inheritance." (The New Columbia Encyclopedia, 4th ed., 1975).

6. Ethnicity - "Those behavioral and ideational characteristics of individuals or groups that identify them as belonging to a distinct culturally recognized and named category in terms of presumed shared cultural heritage and or presently active cultural characteristic." (Hogle)
7. Health Care Provider/Health Provider - Any member of the health team--health educators, nurses, physicians, dentists, allied health workers, social workers, medical secretaries, receptionists, hospital volunteers, counselors, administrators, and religious leaders--in contact with patients, in every health care setting.

8. Health Education - "The science of self-help. It is the discipline which strives for client self-sufficiency by assisting patients and consumers in the assumption of responsibility for their own bodies, health and actions. It is necessarily a philosophy of activation." (Roter)

9. Patient - "From the Greek "pēma" (suffering) la: an individual awaiting or under medical care and treatment b: the recipient of any of various personal services 2: one that is acted upon." (Webster's Seventh New Collegiate Dictionary)

10. Patient Education - "Process of changing individual patients' behavior from acts that have a detrimental effect on health to those that are conducive to present and future health. Dissemination of information towards maintaining and maximizing an individual's state of wellness, preventing and incidence of sickness, and coping with health conditions that require self-care." (McCaughrin: 1, 1981)
Patient compliance is defined as the extent to which a person's behavior—taking medication, following diets, or executing other lifestyle changes—conforms to medical or health advice. In the past ten years patient compliance has become an active research area involving medical and behavioral scientists.

(Bruer: 1119, 1982)

Compliance/Patient compliance is a very complex and critical issue in health care. Its importance is attested by the numerous and controversial research studies, workshops, books, articles in journals, newspapers and other media in the United States and abroad. Definitions of compliance vary across the literature. However, it may be simply defined as "following the health care providers instructions/recommendations/medical regimen."

Types of compliance discussed in the numerous studies and articles relate to drug/medication-taking, weight reduction, diet restrictions or additions, attendance/appointment-keeping, exercise, rest, and irregular discharges—patients drop the treatment or the physician, and/or remove themselves from the health care setting (Kidwell and Withersty, 1980).

Some health educators, medical researchers, and other authorities are uncomfortable with the term. Carol D'Onofrio
(1980) finds it "repugnant" because "it implies subservience, dependence and unquestioning obedience to authority." Hulka (1979) is concerned with its opposite, "Noncompliance," because the term "often implies a pejorative affect toward patients who are presumed to be at fault" (Hulka: 63, 1979). Rosenberg (1976) suggests the term "adherence" instead of "compliance" because "adherence" has much less of an authoritarian tone and implies a willingness to participate. Stuart (1982) agrees with this choice, indicating that "Compliance" has a coercive tone "which indicates adaptation of behavior to the wishes or commands of another individual, while 'adherence' implies willingness to support or maintain one's loyalty to another's request."

David L. Sackett (1976, 1978, 1979), one of the partners of the most frequently quoted works on compliance, says that both terms—"adherence" and "compliance"—were considered at the Workshop/Symposium on Compliance with Therapeutic Regimens at McMaster University in Ontario, Canada, in May 1974, but that "Compliance" was the selected term. Sackett defines compliance as:

the extent to which the patient's behavior (in terms of taking medication, following diets or executing other life-styles changes) coincides with the clinical prescriptions. . . the patient yields to health instructions and advice, whether declared by an autocratic, authoritarian clinician or developed as a consensual regimen through negotiation between a health professional and a citizen. .

(Sackett: xi, 3: 1976)
Another term suggested is "patient's cooperation with prescribed treatment," a rather lengthy synonym for "Compliance," advocated by Friedman and Dimatteo (1979).

In personally preferring the term "Compliance" to describe the process of "following the health care provider's instructions," (or "seguir las instrucciones medicas," in Spanish) its opposite, "Non-compliance" is the focus of health researchers and providers. When the results of non-compliance are considered "a tragedy" and "sabotage" to treatment, it seems only natural that the immediate reaction of most health workers is to educate the patient/client to comply. Stone express this commitment by saying of non-compliance:

Why would someone who has gone to the trouble and expense of seeking out a physician, of undergoing arduous or uncomfortable tests and other diagnostic procedures, and of purchasing drugs and devices on the advice of the physician, then fail to follow the recommendations? Such "non-compliance" is but one outcropping of a condition that is extraordinarily widespread in our society.

(Stone: 5, 1979)

Sehnert (1980) reports that in a survey distributed at one of the meetings of the American Academy of Family Physicians in 1976 the doctors were asked, "What is the single, most annoying thing that patients do?" The answer was, "Failing to follow instructions on diets, medications, bed rest, and so on."
This frustration and even hostility experienced by providers on account of their patients/clients' non-cooperation, is reported in the literature as quite common (Saunders, 1954; Rotter, 1977; Taylor, 1979; Hopper, 1981). Besides the wasted efforts, untold hours of time and patient suffering (Chillag, 1980), and the astronomical costs (Eastaugh, 1982, Gunter-Hunt, 1982; Becker, 1979) the patient/client does not receive the full benefits of the expertise of health care providers (Stone, 1979).

Strain (1982) also comments on the frustration of providers because recent studies reveal that one-fourth to one-half of patients in the medical setting fail to comply with prescribed medical regimen. This naturally, affects the patient provider relationship--a major factor in compliance.

**Extent of the Problem of Non-Compliance:**

How widespread is this problem is examined in all settings and all socioeconomic groups throughout the literature. Findings are quite unanimous in showing that non-compliance is almost universal (Hayes-Bautista, 1976), and cannot be explained as a characteristic of any particular personality types or groups (Becker, 1976; Gunter-Hunt, 1982; Rotter, 1977).

Eastaugh (1982) mentions that out of 9 million Americans
that have used anti-hypertension medication, about 5 million could be helped by adhering to the regimen.

Cummings et al (1982) reveal that about one-third of patients fail to comply with both dialysis fluid limitations and diet restrictions. Also, about half of the patients do not follow instructions for medications.

Gotsch and Liguori (1982) in their review of the literature of non-compliance with antibiotic therapy—one of the most common types of non-compliance with medication-taking—state that the rates are high: between 20% to 60%—with 83% in some groups.

Stone (1979) reports that one-half of all patients fail to follow fully the treatment prescribed for them.

Rapoff and Christophersen (1982) report that between 15% and 93% of patients fail to comply with prescribed medical regimen of all types; at least one-third of all patients fail to comply with short-term regimens (such as a 10-day antibiotic treatment); and 50% of patients on long term treatments, such as hypertension.

Haynes (1982) the other famous partner in compliance literature mentions that "non-compliance has evolved from an act of self-preservation into a tragedy." He mentions that in ambulatory settings the majority of patients fail to comply with treatment or health advice—whether for prevention of acute or chronic disorders. Haynes mentions that recent surveys indicate that fewer than 30% of hypertensive
patients benefit from treatment because of lack of compliance with medical advice.

Becker (1976), referring to non-compliance as "a critical problem in treatment of disease," cites several studies, showing very thorough statistical analyses. He reports that 40% of clinic outpatients studied had admitted that they never intended to comply—either by taking medications or returning for follow-up appointments. Thus, non-compliance is found among all levels of society, regardless of demographic, social, and/or personality groups. Also, knowledge of illness of treatment among individuals did not make much difference.

Although some studies (including a recent one by Morse et al, 1984) claim that minorities and members of the lower socioeconomic levels are responsible for most appointment keeping non-compliance, a local study (Hertz and Stamps, 1977) refutes that claim as being inconclusive, invalid, and mythical. Hartz and Stamps say:

... the conclusion that low-income patients break appointments more frequently than other has become accepted in such a way that ... This alleged tendency ... is explained in a variety of ways, including ethnic background, low education level, cultural barriers. ... Too few researchers have carefully analyzed the relationship between the type of health care most often delivered to these low-income population groups and the facility's impact upon broken appointments. ...

(p. 1034)

Gunter-Hunt, Ferguson and Bole (1982) report a range...
between 15% to 44% of non-compliance with scheduled appointments in nearly all medical settings. These researchers point out that not only do patients fail to receive appropriate medical care, but since the staff and facilities are underutilized, there is an increase in medical care costs. The authors also agree that non-compliance occurs among all socioeconomic groups, settings, and persons—regardless of characteristics of personalities. In fact, providers cannot accurately identify non-compliers (Markel, 1984).

Some of the factors affecting compliance are discussed next in order that providers may become aware of their influence on patient non-compliance.

Factors Affecting Compliance/Non-compliance:

Several studies deal with the numerous factors involved in not following the provider's recommendations. Cummings, Becker, Kirsch, and Levin (1982) cite the following psychological factors as barriers to compliance/adherence among hemodialysis patients: cost of treatment, health beliefs and benefits about taking the medicine, diet restriction, patient's perception of susceptibility and severity of disease and understanding of purpose of diet, complexity of regimen, disruption of family life-illness interfering with time spent with spouse and role as parent, causing problems with marriage, being away from home. Also stress, poor
recall, and expectations and support from members of the medical staff. Modifications of personal habits—such as diet and alcohol consumption—appear to be the hardest to follow. It is difficult to crave for foods not allowed in the diet, limit liquids/fluids, and to follow the complicated regimen/instructions. Cummings et al comment that in chronic disorders the length of time of treatment is negatively associated with compliance. That is, the longer the treatment, the poorer is compliance. Naturally, provisions should be made for individual differences and varied environments.

In citing the "monumental" work of Sackett and Haynes, Chillag (1980) mentions over two hundred determinants of compliance investigated, such as: age, sex, marital status, socioeconomic status, knowledge of disease being treated, income, psychologic factors, severity of illness, duration of therapy and disease, number of medications, side effects of drugs, pain, anxiety, stress and cost. This particular cost factor among the elderly and minorities with chronic disorders is very significant in Chillag's work and makes it an excellent reference.

Other important factors that influence non-compliance are: long waiting periods, lack of accessibility to health facilities, transportation, child care services, work schedules, embarrassment from public display or from insertion of instruments, failure to involve the patient with
treatment, race, ethnicity, language, culture, rurality, urbanity, migration, acculturation, unemployment, and poverty.

Poverty makes a tremendous difference in the perception of illness, the need for medications, and the duty to comply. Susan Hopper (1981) expresses the impact of lifestyle changes on meals, physical activities, family roles, and unemployment among lower socioeconomic groups. Her study is thorough and valid; it portrays the stigma of dependence and despair caused by unemployment. The individual feels worthless, with little hope or desire to attempt any measure of change in lifestyle. The cost involved in a diet of fresh fruits for the diabetic patients in her study account for the lack of complying with diet restrictions and additions. As Hopper states, the perception of symptoms among lower income individuals differs from middle-class clients. She says:

Among lower income individuals one-half to two thirds usually feel sick or have a set of symptoms that make them feel less healthy than their children or than their parents or grandparents at a comparable age.

(Hopper: 12, 1981)

Yet these individuals were considered "incapable of complying" by their practitioners. As explained under "The Health Care Provider," before prescriptions are given or changes in lifestyle are recommended, the available resources of the patient must be known by the providers.
Changes should not be based solely on provider's expectations—particularly in the case of the poor.

Becker (1976) also agrees with the importance of the relationship between provider and patient. He suggests a "health beliefs model," which takes into account the perception of the individual about his susceptibility to the severity of the disease and his resources—particularly the influence of the family. In carefully reviewing and statistically analyzing a variety of compliance studies, Becker comments:

In attempting both to discover and better understand the determinants of patient compliance behavior, hundreds of investigations have been undertaken, ranging in emphasis from medical and economic considerations to dimensions which are mainly demographic, socioeconomic, sociocultural, personal and motivational, geographic, organizational, and social-interactive. . .

(Becker: 96, 1976)

But the most important/critical problem in the treatment of disease in Becker's opinion is "obtaining the patient's cooperation with the required therapeutic program." That is compliance.

Pawlicky (1982) also comments on the negative influence of non-compliance on the patient-provider interaction. He warns providers to remember that with the reduction of severe symptoms there is a change in the patient's behavior, with a lessening of the provider's influence and control
to dictate instructions. The patient/client must be made aware that taking medication is a way of helping eliminate symptoms entirely—not just temporarily—and to avoid possible complications. Pawlicky suggests that more studies should be undertaken to ascertain factors affecting compliance/non-compliance, but that consideration of the environment should be stressed as a very important factor.

Another factor that should be considered is illiteracy, since many of the well-intentioned studies and recommendations fail to take into consideration the millions of illiterate individuals who may want to follow directions and comply but do not have the skills to do so. Of course this problem of literacy is compounded when monolingual Hispanic individuals are involved; the situation then is much worse. It does contribute to feelings of hostility against "non-compliant" patients. (Illiteracy is further discussed under "The Patient-Provider Interaction," which follows shortly, and on Chapter IV - Hispanics in the United States.)

Because of the many factors that influence compliance/non-compliance and the proliferation of studies with conflicting and arbitrary operational definitions, more strategies rather than studies are needed. Comparing compliance to a culinary delicacy, Haynes (1982) suggests the following recipe to achieve success:

... we must continue to search for an elemental diet ... to nourish compliance, the contemporary compliance chef must con-
In order to achieve compliance, essential ingredients include reducing waiting, using reminders for appointments and medications, increased attention and supervision, modification of the delivery of health services may be required before we can hope to achieve uniform success.

Following these recommendations, the most salient factor affecting compliance—the patient-provider interaction—will be examined next. The literature review will be followed by a discussion of the roles of patients and providers.

The Patient-Provider Interaction

Interaction between patients and health care providers as whole human beings involves a communicative potential which by far exceeds the treatment of the disease. Holistic, loving, or humanistic health care is thus reflected in the manner in which a patient is regarded: he is a holistic human being with an interrelationship of mind/body/spirit, and he is more than a disease; the health care provider is more than a trained technician.

(Adams, Bello, Chow and Martinez: 218, 1976)

A Humanistic Model of Health Care is proposed by Diane Adams, Teresa Bello, Effie Chow and Laura Martinez (1976) reminding health providers that it is not enough to be efficient and scientific, but that the healing process requires interpersonal communication—warmth, empathy, understanding, care. The patient-provider interaction thrives on communication, respect and trust.
The importance of the patient-provider interaction in health and medical care was thoroughly discussed in an issue of the *Journal of Social Issues* (Winter 1979), entirely devoted to interpersonal relations in health care. The issue editors, Robin DiMatteo and Howard Friedman, quoted frequently throughout this work, emphasize the need for a more humanistic and holistic approach in health care, stressing the role of interpersonal relations as "real medicine," while underlining the importance of both verbal and non-verbal communication in health care. This communication is essential in the patient-provider interaction.

Di Matteo states:

"There is evidence that the quality of the interpersonal relationship between the physician and patient can significantly influence the outcome of treatments that may appear to depend solely upon technical factors. . . A number of studies reveal that patients clearly desire a good rapport and clear communication. . . and when they receive it, they are less likely to turn. . . to quacks and charlatans or to bring medical malpractice suits. . ."

(DiMatteo: 17, 18; 1979)

Stone (1979) also mentions a power and control conflict in the patient-provider interaction—a real struggle. He states that each patient has his/her own expectations, goals and constraints. In particular, patient expectations deal with the preservation of self-respect, limitations on invasion of privacy, cost containment, and also the need for dependence and nurturance. Stone is one of the authors
that is not in agreement with the concept of "the patient as a partner," or the patient as a decision-maker. He mentions that the Mutual Participation Model is foreign to medicine, and is not appropriate for all patients, especially "children, or persons who are mentally deficient, very poorly educated, or profoundly immature." This view seems to coincide with that of other authors mentioned under different sections of this work, concerning decision-making. In certain cultures, like that of Hispanics, decision-making, especially in health matters, is not expected of the individual. The family has a great input. Often, in the lower socioeconomic groups, patients expect the provider to fulfill the role of expert and authority figure--rendering a service that is expected. (This view is further discussed in the Quesada article, mentioned below.)

Another example of the patient-provider interaction as a struggle for power and control is an article by Hayes-Bautista (1976) concerning a study of 200 urban Chicano patients in the San Francisco Bay area. Hayes-Bautista mentions several levels of "deals" on the part of the consumer/patient. These deals may be also called "bargains" that help to cope with the "power-control" conflicts among patients and providers. Patients develop tactics to gain control over their treatment and by not complying with the regimen. This is a recount of incidents of patient-provider interaction as perceived by patients. In extreme cases
patients will resort to termination of treatment to exert control. Actually the patient attempts to exert some control in order to modify a treatment that is perceived as unsatisfactory. Hayes-Bautista warns the reader not to consider every incidence of non-compliance a struggle for control, but as a possibility for a model of patient behavior.

Quesada (1976) speaks about a "patron-peon" dependency syndrome, when the patient does expect the expert to provide treatment "in some kind of authoritative fashion." Quesada discusses problems encountered by Mexican Americans concentrated in California, Arizona, Colorado, New Mexico and Texas. His paper addresses problems of communication affecting the health care of that group. He mentions that Mexican Americans, or Chicanos, not only find themselves as speakers of a foreign language in an English-speaking country, but are also part of the lower socioeconomic group--"with all the cultural values that this implies." Because of this language difference there are problems, Quesada says, since people assume that by knowing the Spanish language patients can be helped and the patient-provider interaction enhanced. Not so, says Quesada. A knowledge of the culture is important. He says:

It has been said repeatedly that Mexican Americans and other Latin Americans have much more paternalistic dependence. In other words, the average man will establish different "patron-peon" relationships for
Quesada speaks about perception of symptoms influenced by social class. Patients want to be relieved of pain now, immediately; these Mexican-Americans are interested in short-range therapy, not in preventing symptoms in the future. He warns providers of a lack of concern on the part of the poor for medically significant symptoms--which rests in part on lack of information. He also mentions that because of lack of education poor individuals might react negatively to the insertion of instruments and other technological treatment. Therefore, providers must be aware of these cultural perceptions in dealing with poor Mexican Americans. Doctors, in particular, should provide more answers and not ask so many questions. This affects the doctor-patient-relationship, especially if the physician refers the patient to other specialists to confirm his/her diagnosis. The value of this paper is in its explanation of sociocultural, linguistic, familial, and health practices that may affect the patient-provider interaction--particularly in view of its discussion on
authority figures—and their influence in the health care of Mexican American patients in the lower socioeconomic groups. Quesada's paper does not generalize. It gives excellent references for providers to research and develop strategies for better compliance and communication between patients and providers.

Inui, Carter, Kukull and Haigh (1982) discuss "face-to-face" interactions between patients and providers fostering communication and patient compliance with medications. They comment on the numerous studies undertaken on these personal "encounters that are pivotal events in rendering medical care," from several disciplines such as anthropology, psychology, linguistics, operational research and clinicians. While reporting high rates of non-compliance with drug/medication-taking, Inui et al give several reasons for the problems such as: because of stress the patient may simply forget or maybe does not hear the information; the provider may be too busy to supply enough information or make explanations; the patient may be too shy; or the prescription may be given to persons other than the patient. The authors also comment on the structure and tone of language in clinical encounters as being very effective in encouraging communication and better compliance with drug/medication taking.

Hulka (1979) also comments on the importance of the patient-provider interaction on compliance. Focusing on medication-taking and compliance, she explains that a great
portion of what might be considered lack of compliance may actually be inadequate communication between the physician and the patient. The physician may be actually unaware that the patient is not taking the medication, while the patient may be intimidated and may withhold information from the provider. Hulka states that there are four types of drug/medication errors:

1. omission rate: proportion of drugs patient is not taking.

2. commission rate: proportion of drugs patient is taking, but that the physician is not aware of.

3. scheduled misconceptions: proportion of prescribed drugs for which the patient did not know the correct schedule.

4. scheduled non-compliance: proportion of prescription drugs taken by the patient for which the patient knew the correct schedule but did not take as prescribed.

Hulka suggests a single regimen, compatible with a patient's lifestyle in order to avoid errors. She also comments on the fact that the more drugs the physician prescribes, the more the patient omits. Also, Hulka says that when a patient shows a poor response to medication, the physician should first consider which drugs have been taken and how they have been taken, not only add more of the same or change to different drugs.
Citing the extensive literature that exists on compliance with therapeutic regimens, Hulka, Cassel, Kupper, and Burdette (1976) mention that rarely have researchers dealt with the role of the provider in non-compliance; there may be an incongruity between what the patient thinks he is supposed to do and what the physician thinks the patient is doing. Just as patients are supposed to be responsible for following doctor's instructions (compliance) then it should be the providers' responsibility to "know if and how often the patient takes the drugs." This interaction is termed "physician-patient concordance" by Hulka et al. (This suggestion of "concordance" rather than "compliance" is rather appealing, but was not noticed again in the health literature researched for this work except in the Miller [1979] article). Therefore, in dealing with cases of non-compliance in medication-taking, providers must suspect communication problems, especially among patients with chronic conditions who are frequently confronted with multiple drugs and changing drug regimens (Hulka et al: 847, 1976).

Professor John Mazzullo (1976), a physician and toxicologist, also agrees that it is the responsibility of the physician to see that prescriptions are taken properly by the patient. He warns about patient confusion, drug ineffectiveness, and toxicity with medications. Mazzullo says that prescriptions must be written legibly, accurately,
and clearly in order to avoid problems. Also, misinterpretations arise from careless use of words and phrases, like the word "evening." "Take one tablet at breakfast and one in the evening." Is this before, after dinner, at bedtime--when? Mazzullo suggests "every 12 hours." He also complains about poor penmanship of providers that may be easily misread by pharmacists and nurses. Mazzullo mentions patient education and comprehension as important factors in the patient-provider interaction basic for quality health care. He says:

But the process of educating the patient is crucial to establishing the close working relationship between physician and patient that is the "sine qua non" of optimal care. . . .Knowing the patient's habits and instructing him about his therapy in terms of those habits. . . .the prescription can serve as a starting point for patient education.

(Mazzullo: 29, 1976)

In a local article (Springfield Union - 3/21/83) Dr. Bruce Woolley, professor of applied pharmacology and therapeutics at Brigham Young University, is quoted as saying that the physician, the patient and the pharmacist have a responsibility in handling prescriptions. He also agrees that prescription labels are not specific, like "Take four times daily." Awake or during a 24-hour period? The article mentions that Americans spend about 286 billion dollars annually on health care costs, and that part of this money is wasted. Citing the Boston Collaborative Drug Surveillance Study, it is stated that there is a drug related
death for every two hundred people that are hospitalized, while the nation's health bill for hospital days devoted to care of drug-toxicity patients is in excess of 3 billion dollars for one year! The article criticizes the United States for being a drug-oriented society, with people demanding prescriptions for any health condition. Part of the blame must be shared by the media, especially television. The fact remains that the communication channels between patients and providers is faulty, which reflects in the patient-provider interaction.

Barbara Roter (1979) also emphasizes the patient-provider relationship as "the variable most consistently related to patient compliance." She cites that among the caring functions of providers that are identified by patients as the most important aspects of their treatment are: a) personal contact b) communication c) concern. Roter speaks about "unilateral decisions" on the part of providers—particularly surgeons—insensitive to psychosocial needs—dominance through default of patient—when patients fail to request information about their treatment. Furthermore, Roter also mentions a lack of communication between providers and patients that is even expected—due to the traditional passivity and powerlessness of the individual in the sick role. There is a need to resocialize the provider and educate the patient/consumer through a philosophy of patient activation. This is a characteristic of health education.
The activated role of the patient is encouraged by Roter as an important factor in the patient-provider interaction from a consumer perspective. (Roter's paper, winner of the 1977 Beryl J. Roberts Memorial Award, is an excellent reference source—perhaps among the best in the literature of compliance and the patient-provider interaction.) However, there are some problems with her recommendations about written instructions, and patients being given a copy of the clinic telephone numbers as well as pamphlets "to take home for further reference." What is not taken into account is that there are around twenty to twenty-five million functionally illiterate adults (Kozol, 1980; Hunter and Harman, 1979) in the United States who are unable to read, count, and/or comprehend written materials. These individuals cannot understand their health providers' instructions—either verbal or written—cannot write, and are too intimidated to request more or simpler explanations and instructions. The limited vocabulary of the illiterate/functionally illiterate patient may not facilitate compliance. Probing and questioning gently may alert the health provider to the understanding or lack of understanding—or even misunderstandings—of certain health instructions. This certainly contributes to "doctor-shopping," patient dissatisfaction, and patient non-compliance.

Grudner (1981) comments on the readability of surgical consent forms. The study explains how five representative
surgical consent forms were analyzed with two standardized readability tests. All forms were written for upper-division undergraduate or graduate student levels, four at the level of a scientific journal, and the fifth one at the level of a scientific academic magazine. The implication? Most of the patients undergoing surgery did not understand their consent form. No wonder patient trust is eroded and patient compliance is many times replaced by malpractice suits! If the patient understands the provider's instructions and diagnosis, then there is no reason to run to the nearest emergency room for a second opinion and perhaps better treatment. This is an every-day happening in local communities, particularly among Hispanics who are used to receiving personalized, simple, rather low-cost health care from Spanish-speaking providers—sometimes folk-healers and traditional medicine experts. If the non-Spanish-speaking provider does not reach them, and the language barrier persists, many of these monolingual patients will flock to the emergency rooms where there are usually bilingual health workers. Therefore, it is very important that instructions be given in simple, comprehensive terms, or that competent bilingual interpreters be utilized. This will result in a better informed and satisfied patient, patient trust, patient compliance and cost-containment—very important in the patient-provider interaction and quality health care.
As to "the language of medicine," Bernard Barber (1979) comments on the problem as follows:

If we turn from assertion to research evidence we can usefully look at two sets of investigations. One has to do with the different vocabularies of illness and health that patients and doctors use; they often do not speak the same language in dealing with one another. The other has to do with a problem defined by doctors as interfering with successful treatment of disease, the problem of noncompliance by the patient with the regimen prescribed by the doctor. Both of these sets of research evidence give us a better understanding of patterns and determinants of language and communication behavior between doctor and patient.

(Barber: 119-120, 1979)

Barber further states that the problems of non-compliance have become even more serious since the end of World War II, after the invention of antibiotics, and the use of specific and effective remedies such as diuretics and psychoactive drugs, "all of which make compliance by the patient a more consequential matter." However, Barber continues, the problem of not taking medicines—non-compliance with drug/medication taking—is not a new phenomena, but "may be as old as medicine itself."

Shuy (1978) cites problems in crosscultural interviews, how providers control the situation, and the intimidation of the patient while the medical history is taken, "even to the extent of offering false information."
further explains that language issues have emerged when dealing with women, minorities, and the elderly. Fortunately, the language rights of patients who do not speak English are now beginning to be recognized in some hospitals. Urging an improvement in the provider-patient interaction through better communication, Shuy recommends: "One place to begin is by comparing how language is actually used with how it could be optimally used. Medicine is a critical area of language and public life."

Patient perceptions, and the concerns of health providers towards patients' feelings influencing levels of compliance are effectively discussed in an article by Falvo, Woelhke and Deihamn (1980). The authors state that "those patients who perceived strongly that the physician had considered their feelings and concerns had proportionately higher compliance rates." Falvo et al recommend a more humanistic approach to the present technological approach to health care. They mention that the patient-provider interaction is enhanced, and compliance with the therapeutic regimen occurs if patients are given clear explanations, with a friendly attitude—considering their feelings and concerns in making recommendations for treatment. However, Falvo et al caution providers that since every patient is different, levels of information may differ; some may want more information than others. Individualizing patient health care by listening to patient's concerns is very important. This skill on the part of the physician to
recognize individual differences must be taught in medical school. The authors say:

Behavioral scientists and others involved in medical education, therefore, share increasing responsibility for incorporating material into the medical curriculum that would better prepare future physicians for their role.

(Falvo et al: 188, 1980)

Finally, Alan Harwood (1980) emphasizes the role of communication and personalized care in the patient-provider interaction and, consequently, compliance—particularly among Hispanic patients and Anglo health providers. Harwood says, "that the interactional and communicational aspects of the provider-patient relationship have no small impact on compliance." Writing about the two largest Hispanic subgroups in the United States—Mexican Americans and Puerto Ricans—Harwood mentions factors that may affect health behavior, such as: social class, degree of acculturation, ethnicity, language, the roles of the family and culture, personalization in treatment, and poverty among others.

Harwood then suggests some strategies that must be observed by providers, to ensure compliance, such as: less complexity of the medical regimen; less expensive prescriptions and treatment; awareness of the interdependence of the individual and the family; understanding modesty and knowledge that discussion of sexual matters between the sexes is taboo; awareness that there is a concern about blood tests—how
much is being taken and what will be done with it; necessity
of finding out if folk healers are also treating the patient
and what medications are used in order to avoid synergistic
effects; need to be familiar with herbs and folk remedies;
not ridiculing folk diagnosis and beliefs; avoiding unrealistic
expectations; identifying family members—authority figures
in the network—to influence compliance in chronic disorders,
particularly when no symptoms are present; importance of
language—ascertaining the level of comprehension of patient's
English or of person accompanying patient; and making sure of
the competence of hospital translators. The list is long
and very important, but above all the strategies to improve
the patient-provider interaction is the importance of patient
education—informing the patient about tests, procedures, side-
effects and treatment—making sure the patient understands.

The above suggestions are made by Harwood under the
Chapters on Mexican Americans, and Puerto Ricans. For this
latter group Harwood adds the classification of "The Hot and
Cold Theory of Foods and Medications—among less acculturated
individuals—and its implication for better compliance and
patient health care. Furthermore, Harwood also mentions the
over-utilization by many Puerto Ricans of the emergency room,
with the advice to providers that these ER users probably have
no family physicians and must be advised of clinics and other
facilities for continuity of care. In his conclusion on the
health of Puerto Rican Americans, Harwood states that the
basic problem is the poverty of the sub-group, with the sequel of inequalities affecting health. He says:

Clinicians who care for Puerto Rican patients by and large treat the somatic effects of social and economic inequality... low income, substandard housing, and poorly designed medical services, contribute significantly to both the epidemiology and medical usage patterns of this ethnic group...

In these encounters Puerto Ricans' cultural conceptions of illness and treatment, their language preferences, their habitual patterns of social interaction, and their expectations of medical care are all pertinent to the therapeutic outcome.

(Harwood: 467, 1980)

In considering intraethnic, intracultural variations and similarities among Hispanics in the United States and their implications for patient compliance and the patient-provider interaction, Harwood has been an invaluable source of reference for this work. Separate sections on Providers and Patients will be reviewed next; hoping that both sections will aid in improving the patient-provider interaction among Anglo health care providers and Hispanic patients.

The Health Provider:

... But clearly there is something wrong with the capacity for sensitivity of the system and many of the health care workers in it... doctors are being trained more as indifferent technicians than compassionate professionals... But the physicians are not the only ones to blame. They are far outnumbered by nurses, clerks, secretaries... and still others... careless and callous... moving your body along as if it were being
loaded on a ship by longshoremen. . . using language you don't understand, or revealing intimate details about your life history or finances in a crowded office where everyone can overhear.

(Lawrence K. Altman, M.D.: E-7, 1983)

The above excerpt—rather long, but invaluable, must be read as a professional exercise in consciousness-raising in the health field. The fact that Altman is a physician makes it even more interesting. He says that "even doctors themselves, when they become patients, fear the vulnerability." But Altman also states that because of the technological nature of modern medicine, treatment becomes more impersonal and dehumanizing.

As mentioned in the Introduction of this work, the operational definition for health provider will be extended to every member of the health team in health care settings—doctors, health educators, social workers, and other health professionals and paraprofessionals, including secretaries, hospital volunteers and even religious leaders. Altman emphasizes the responsibility of all health workers in dealing with patients. It seems that the "professional distance" has been carried to an extreme. The lack of personalization and warmth affects the patient-provider interaction.

Psychiatrist Arthur Kleinman (1981) calls this approach "the veterinary tendency in modern medicine." He makes a distinction between the terms "illness/sickness," as perceived
by the patient, and "disease," as perceived by the provider. Kleinman says that "illness" may—often does—occur without disease. He also states that half of the time visits to doctors are for ailments without any clear biological basis. Furthermore, Kleinman reports that dissatisfaction with quality medical care results in malpractice suits—a trend in many industrialized societies. Blaming Western medicine for the failure to focus on patient's illness, Kleinman suggests the folk healer model based on the findings of a humanistic model of medicine, in which the patient's feelings and beliefs are considered.

It seems unfair to blame Western medicine—also known as scientific, modern, orthodox, cosmopolitan, mainstream medicine—for insisting on a biological or "germ theory" basis for health conditions, since cosmopolitan medicine is based on such a premise. As Pawlicki (1980) has stated:

The medical profession. . . has based treatment upon a medical model in which the focus is upon underlying causes. . . The medical professional is trained to utilize an empirical model concerning matters of physical diagnosis.

(Pawlicki: 25-27, 1980)

That concept is known as the Parsonian medicocenter model, where the sick person or patient assumes the "sick role," is temporarily excused from daily activities, and is relegated to a status of dependency. The provider is then granted exclusive authority and control on behalf of the individual's recovery (Honig-Parnass, 1981).
American sociologist Talcott Parsons (1958) defined the "sick role" as that of a dependent, weak, "passive" and vulnerable individual, relying on the competent knowledge and training of the professional expert—with an obligation to get well—and to further cooperate with the expert in the process of getting well (Ablon, 1981). Thus the concept of compliance is built in the Parsonian model, faithfully followed by cosmopolitan health providers. The roles of the expert and the patient in the Parsonian model are described by Stone (1979) as follows:

. . . the patient comes with symptoms; the expert gathers further data by questions, by observations, and by test procedures. The problem that the patient brought is then given over to the physician. When the physician has concluded that there is a treatable condition, the patient is, more often than not, relegated to the role of passive observer, occasionally being called upon to provide still more information or to submit to still further tests.

(Stone: 47, 1979)

Because of a better informed patient, the "consumer revolt," and the legal implications of the doctrine of informed consent, the Parsonian model is being analyzed and evaluated at the present time, with outcries for a "redefinition of the traditional medical models of the patient-physician relationship" (Roter: 282, 1977). The model was adequate for acute and infectious episodes of illness, where the patient had to rely on the knowledge and expertise of the provider for the resolution of a critical incident. However, in modern times, where antibiotics
have somewhat changed the process of infections, and that "life-style" conditions rather than acute illnesses have become more prevalent in industrialized societies, the Parsonian model must be revised and/or replaced.

Explaining the use of the Parsonian model in "middle class" American Society, (Ablon, 1981), states that the model is not applicable for mental disorders, chronic conditions, or for certain subcultural groups. Implications of using this model for treating the poor, the old, the very young, and minorities are overwhelming. In those cases the model doesn't work.

Hopper (1981), commenting on the limitations of the theory, states that it makes sense in the USA because of the emphasis on values of "responsibility, activity, achievement and independence," but not in cultures/societies where the "sick role" is perceived differently. She states that the theory is not applicable with:

- illness not serious enough to reduce activity, with incurable illness, with illness not leading to medical consultation, and with those that occur among working class peasant, and non-Western populations, among at least some of which being ill in a socially acceptable manner does not require professional legitimation or consultation.

(Hopper: 11, 1981)

In other words, the medicocenter model does not apply to the poor and the needy, the old and the destitute. Yet, medical
education is still based on the classical Parsonian model. (Fortunately, as will be examined later, this approach to medicine is being revised and a more humanistic, anthropological approach to health care is being emphasized. There is a movement among humanistic-oriented providers to change this trend. - Appendix G)

DiMatteo (1979) has reported that in order to maintain and develop the technical excellence of modern medicine, medical students are selected mainly for their scientific abilities with little recognition for what has been known as "the Art of Medicine." Gone are the days when doctors knew their patients as part of their communities, made home visits, and had the time for more chats and amenities with their patients/clients.

Smith (1980) attributes this to fragmentation and specialization of the profession due to expansion of medical institutions. Technological advances, urbanization, population increases, and the demand for more specialized services, have compounded the communication problem, altering the nature of the patient-provider interaction. Differentiation and specialization of medical roles, with a proliferation of paraprofessional technicians, have resulted in a powerful industry in the United States. Unfortunately, the anonymity of the patient has taken place, with a consequent lack of communication and increases in patient non-compliance.
Particularly among minorities and rural people, where personalization and individualized health care are not only expected but demanded, opposition to impersonal approaches on the part of care providers may be reflected in the under-utilization of health care facilities.

Berry, Kessler, Fodor, and Watto (1980) in their report on intercultural communication for health personnel state the need for more training of providers in the background of their patients/clients in order to understand patient's perceptions of health problems. These authors comment that:

While language differences between patient and practitioner may cause misunderstandings, other communication differences may also be present. . . the ethnocentric attitudes of the Anglo practitioner may affect the Hispanic patient's perception of the health care environment. . . The lack of interpersonal conversation with Anglos as compared to Latinos may be perceived as impersonal and may be insulting to the Latino.

(Berry et al: 3, 1980)

It may seem unfair to expect the provider to learn not only cultural traits but also languages. However, in this multicultural, multiethnic society, especially in urban settings where physicians and other health providers prefer to practice, patient needs must be satisfied. If compliance is to occur, practitioners must learn the backgrounds of their patients, their health beliefs, values, expectations, and their past experiences in health settings. Learning just a few phrases in the language of the patient may introduce the provider to
the "reality" of the patient. Good interpreters, trained in language and culture will help, but non-verbal communication is sometimes more effective than words. Besides, "medicalese" is a language by itself and it is not only the non-English speaking patient/client who needs the benefit of interpersonal communication--it is every patient who feels helpless and confused because of the stress of his/her condition.

Saunders (195*) while urging providers to learn about the culture and the language of Hispanics in the Southwest, in order to increase patient compliance and provider satisfaction appeals to the professional honor and good will of providers. Saunders encourages Anglo professionals and officials to become sensitive to the implications of cultural differences of the specific group with which they are working. He suggests a more satisfactory relationship if the authority figure asks the patient "specifically where he was born, where has he lived, how much schooling he has had, and where he has received it, where he has worked and at what jobs, how well he knows English, to what social class he belongs, what religion he professes, and similar types of information." In short, Saunders is talking about the importance of a good medical history in order to become acquainted with the patient/client. Saunders continues:

Such knowledge, although not of absolute predictive value for an individual, might help to explain such behavior as nonattendance at clinics, failure to have children immunized, the use of laymen or marginal professionals in the treatment of illness, reluctance to enter or remain in a tuberculosis sanitarium, leaving a hospital against medical advise, the copper
bracelets to ward off disease—even during hospital confinement—and similar actions and attitudes that are puzzling from an Anglo point of view...

(Saunders: 98-99, 1954)

In other words, Saunders is describing non-compliance among Hispanics and suggesting strategies to improve patient compliance and the patient provider interaction.

Therefore it is very important to introduce health care providers to an "introspection exercise of ethnic/cultural identify—suggested by Suzuki (1982)— and included as part of this work under Appendix F. But before attempting to interact with patients, providers must know their own backgrounds and ethnic roots. This is true of teachers and health educators in particular. Cultural sensitivity must start with the provider and only then can it be effective as a service to patients/clients.

In closing this section on providers it is important to recognize that factors affecting compliance can be generalized and applied to foster quality care with patients of diverse backgrounds. A brief section on patients in general is presented next, followed by two chapters on the patients chosen in this work: Hispanics as a group, and Puerto Ricans as a sub-group.
The Patient:

Until recently, the individual has felt helpless in his role as patient—and small wonder. Stripped of his individuality, as well as his belongings, he is thrust into an alien environment where he has little control over what happens to him. He is surrounded by unidentified faces and unidentifiable equipment. His privacy is invaded, his dignity lost. He hesitates to complain or criticize because of fear of reprisals... Underlying all this is his fear for his health and even his life.

(Kelly: 26, 1976)

Kelly's description of an individual in the role of "patient" may perhaps sound a little exaggerated, but conforms with some of the perceptions of individuals in different health settings—especially those patients/clients that are hospitalized or institutionalized. The "sick" role casts the individual in a passive, vulnerable, and compliant role. Particularly in the so-called "Western" medicine system, (also called scientific," modern," "orthodox," "cosmopolitan," and "mainstream" medicine—as was explained in the previous Section, under "The Health Provider"), the ailing individual assumes a dependent role, abdicating power and control to the "expert," or authority figure, the provider. Mainly, this "authoritarianism" is usually reserved for physicians, but may be extended to any other health care provider.

Patients that are non-compliant are considered "immature," "paranoid," "hostile towards authority figures," "impulsive,"
and "obsessed with 'dependence'" (Komaroff: 833, 1976); "bad," "suspicious," "reactant" (Taylor, 1976); "recalcitrant," "defaulter," "difficult," "unreasonable," and "demanding" (Powers and Ford, 1979). Taylor describes the "bad patient" as:

... not seriously ill but complains and demands attention anyway. This patient often plays a consumer role insisting on his/her rights as a patient especially the "right to know"... insistence on autonomy... right to be well informed... While a minority, their numbers are substantial enough to constitute a major medical problem.

(Taylor: 162, 174; 1979)

In contrast, patients that are compliant are "good," "cooperative," "undemanding," and "accepting" (Powers and Ford, 1979).

Taylor (1979) discusses the problems faced by patients in hospital environments, with "depersonalizing" effects on the individual, loss of freedom, and control. She explains that this depersonalization of the patient is done through routine treatments, little information, bureaucracy in hospitals, and routine procedures. Both the "good" and "bad" patients may sustain health risks; the "good" patient because of anxiety and/or depression and helplessness, and the "bad patient" through "reactance"—an angry reaction against "the abrupt and seemingly arbitrary withdrawal of freedom." Taylor suggests that seventy-five per cent of hospital patients are thus socialized, while the remaining twenty-five percent
become part of the statistics of "difficult," reactant patients who insist on retaining control and wish to be treated as informed consumers of health care. These patients, remarks Taylor may be medicated, tranquilized, even discharged prematurely—to get rid of—and may actually run health risks. But Taylor also states that "good" patients may feel helpless, often angry and irritated, which may result in stressful situations actually detrimental to their recovery. D'Onofrio (1980), citing incidents of unnecessary surgery, prescription of drugs, and diagnostic inaccuracies, suggests that "bad" patients get better quicker.

Weintraub (1976) also justifies the behavior of some non-compliant patients in omitting medications and procedures because of adverse side effects such as nausea, headaches, sleepiness, nosebleeds, financial considerations, and fear of too much medication—among other valid reasons. He differentiates between "intelligent non-compliance" and "capricious compliance." Weintraub, however, is also critical of those patients who take unnecessary, many times serious, and even fatal risks by not following their physicians' instructions with medications, thus "failing to achieve the therapeutic benefits of necessary drugs, aside from the high costs involved." But Dr. Weintraub also warns colleagues about an overreaction to patient compliance and drug efficacy as follows:

*Underlying the brouhaha over compliance is the physician's belief that the dosages and dose*
schedule prescribed and the agent chosen are the most appropriate for the patient and for the disease process being treated. Such confidence in our diagnostic and therapeutic acumen imparts an aura of physician omniscience. Imperiously assuming that our designated therapy, taken as prescribed, is the sole cause for patient improvement... dangerously oversimplifies the complexities of therapeutics and patient compliance.

(Weintraub: 40, 1976)

Weintraub suggests tailoring therapy to individual patient requirements and characteristics, and better communication between patients and providers.

The need for "activating" the patient and redefining the traditional Parsonian, medicocenter model (mentioned under the previous Section, "The Health Provider,"") is now being encouraged by a more informed consumer, the doctrine of informed consent, patient rights and innovations in the self-care movement (Roter, 1976); (Squyres, 1980); "the revolt of the patient" (Annas, 1978; Altman, 1983); and the adoption of alternate sources of health care (Kleinman, 1981). These innovations are reflected in the Kelly quotation, cited at the beginning of this Section, "Until recently. . . ."

This is directly related to the doctrine of informed consent and the right of the patient to be competently informed about his/her condition. This "right to know" and the educational default of health providers is explained by Rosemberg (1976) as a failure because of the lack of carefully planned
health education programs to instill adherence—"uncoordinated efforts of individuals untrained in educational principles, methodology, or educational research." Rosenberg further states:

... In short, patient and family education, if provided, is usually on an incidental, accidental, ad hoc basis... the patient who does not take his medication as prescribed, does not adhere to a special diet, does not maintain an exercise program, etc. Health professionals must not forget that the physician no longer makes decisions once he or she has prescribed... The patient makes decisions regarding adherence and in order for him to correctly make his decisions, he needs to know not only what and how, but why, what, if, what if not, etc.

(Rosemberg: 95, 96; 1976)

In this regard, Parry (1981) calls the right to know "a basic human need; the right to know when you are sick, what is happening to you, how it is happening, by whom, and under what condition of risk..."

Issues of legal liability in patient education are discussed by McCaugrin. He warns providers that they must be sure that the patient understands the procedures, and that if there is injury to the patient they may be sued. McCaugrin says:

Until and unless a patient understands the educational message, he or she is powerless to influence what happens or is done to his or her body. Thus if providers deliver information about contemplated procedures and treatments that the patient is unable to understand, the providers are in a legally vulnerable position if the performance of those
procedures and treatments results in injury to the patient.

(McCaugrin: 2, 1981)

However, McCaugrin also states that just as providers have duties and legal responsibilities, so do patients, and it is the duty of a patient "to follow the reasonable instructions and submit to the reasonable treatment prescribed by the physician" (McCaugrin: 4, 1981). That means that we are back to the compliant patient in the medicocenter, Parsonian, model. Compliance is built into the model. But patients are seldom told about their rights or responsibilities in medical/health settings—specially about financial matters. Since this paper focuses on patients that are mostly monolingual Spanish-speaking individuals, unskilled, poor, young, and rural, and mainly Puerto Rican, it is very probable that they will not be aware or they will not have been told of their rights and responsibilities in health settings due to language barriers. Therefore, recommendations of a participatory role of the patient in his/her own treatment, decision-making, and the role of the patient as partner/participant and manager of his/her own health care may be controversial. While several concerned health professionals (Hefferin, 1976; Bowler, 1976, Moriski and Deeds, 1980; Powers and Ford, 1976; Mazzullo, 1976; Roter 1976; Gunter Hunt et al, 1978; Saunders, 1954; Hayes Bautista, 1976; and D'Onofrio, 1980—the "participatory" role of the patient in health education—) recommend an active
patient participation, it will be important to listen to other authors.

Stone (1979) and Rund and Krause (1978), join Quesada (1976) and Alvarado (1978) in questioning the decision-making, mutual-participation theories proposed by well-meaning, kind mostly middle-class or middle-class oriented health workers. As mentioned under "Hispanics" and "Puerto Ricans" there are some cultures that do not consider it a stigma to be dependent or interdependent—in the Hispanic case—on the family. As Quesada (1976) and Hayes-Bautista (1976) so eloquently express it, Hispanics (mostly the members of lower socioeconomic sub-groups) are quite concerned about making decisions without the family input. Therefore, "informed consent," "the right to know," and "decision-making" behaviors may be more popular among middle classes in the United States. The poor, the uneducated, the newly arrived Hispanics may be unable to exert those rights because of serious barriers to their health, such as: language, culture, acculturation, illiteracy, migration, rurality, unemployment and poverty in general. These are the real victims that must be helped, but within the context of their own culture and familial traditions. These individuals, mostly monolingual are described as:

... Health statistics highlight the fact that poorer populations, often non-white ethnic groups, experience also poorer health than other segments of society. Disenfranchised from many benefits and services of society by their poverty and ethnic identities, persons
of these populations from their first help-seeking experience, enter the medical system as stigmatized patients.

(Abion: 7, 1981)

This is a very important factor in the patient-provider interaction. How to deal with "problem patients," "hateful" and disliked patients. Elizabeth M. Hooper et al have addressed this problem under the title, "Patient Characteristics that Influence Physician Behavior" (1982), a realistic factor in the patient-provider interaction. These authors mention "empathy behaviors significantly higher with Anglo-American than with Spanish-American patients," and add that

. . . On the whole, then, well-groomed, elderly Anglo-American women received the highest rated physician behaviors, while disheveled, young Spanish-American males received the lowest rated behaviors. . .

(Hooper et al: 636, 1981)

Furthermore in justifying "differences in rating of physician behavior with the different types of patients," Hooper et al make the most devastating comment uttered in health care:

. . . The purpose, after all, of the patient's visit to the physician is the provision of medical care, not an exercise in courtesy, communication or empathy. . .

(Hooper et al: 636, 1981)

These words make it imperative to redesign the curriculum of health practitioners, sensitizing them to the real needs of
their patients/clients. It is exactly communication, empathy and understanding that are sorely needed in health care and that affect the patient-provider interaction.

As an afterthought, Hooper et al concede:

On the other hand, data from other studies and our own preliminary data show that such physician behaviors as courtesy, interviewing, and information giving do correlate with patient satisfaction... and with subsequent patient compliance with their medical regimens... Therefore, it is legitimate to ask whether the decrease in ratings of interviewing skills when physicians were working with Spanish-American patients, for example, might contribute to poorer medical care for these individuals.

(Hooper et al: 636-631, 1982)

Because of the pain and conflicts inherent in the above quotation, which may reflect current patient-provider interactions among Puerto Rican American patients and Anglo health care providers in this area of Western Massachusetts, the next Chapters will review the historico-political and sociocultural backgrounds of Hispanics and Puerto Rican patients. A brief reference to the immigration experiences of other ethnic groups in the United States precedes the Chapters on Hispanics and Puerto Ricans.
Immigration in the United States:

Until late in the nineteenth century, this nation was considered by its majority to be a white Protestant country; at some time near the turn of the century, it became a white Christian country; after World War II, it was a white man's country. During the past several years it has become a multi-ethnic, multi-racial country, intensely aware of differences of every kind. . .

(Ravitch: 228, 1976, mentioned in Let Me Be Me, 1980)

Before attempting to discuss the history and culture of Hispanics in the United States it is important to recall the mechanism of "ethnic succession" in this country, suggested by Thomas Sowell (1981). This concept explains how one ethnic group replaces another in neighborhoods, jobs, schools, and other institutions. Sowell proposes that many of the problems of the poor and powerless remain the same, "whatever group fills the role at a given time." He further states that this "ethnic succession" becomes generalized in other functions, such as leadership, throughout neighborhoods. Thus, the power of teachers, law officers, union members, and blue collar workers are transferred and "reshuffled" among ethnic groups throughout the history of the United States. But Sowell feels that progress itself is pervasive, and that there are wide variations in the rates of progress among American ethnic groups.
An important distinction that Sowell makes is in the term "immigrants." In contrast to the statements made by public figures like JFK saying "This is a country of immigrants," Sowell divides the newcomer groups into four categories:

1) refugees: who "fled in whole family units burning their bridges behind them, and arrived in the United States committed to becoming Americans." 2) sojourners: "mostly men, and with the intention of returning to their native lands, so that Americanization in language, culture, or citizenship had a low priority for them." He gives as an example the early emigrations from Italy, China, Japan, Mexico and currently Puerto Rico. 3) Sowell mentions "true immigrants," who were neither refugees nor sojourners—they chose to come to the USA to settle at a place and time of their choice—like Germans or Scandinavians. 4) Finally, there were those who did not choose to come to the USA but were forced and brought as captives/slaves; these constitute the descendants of most black families in the USA.

Because of political reasons it might be possible to place Puerto Rican Americans under section No. 4, because when Puerto Rico was given to the United States by Spain as spoils of war, Puerto Rico became a colony of the USA, though with the status of "Free, Associated State" ("Estado Libre Asociado," in 1952. Many Puerto Rican Americans do not forget the circumstances; and "colonial" feelings seem to influence current negative attitudes in some of the inhabitants of the island and the mainland.
Some Mexican American groups and the so-called "Spanish American" groups, whose ancestors may be traced to the Conquistadores in the Southwest of the United States, could be considered in the fourth group since many families have inhabited that area and have never left their land for many generations. Of course, one can argue further back to the rights of Native Americans, the true owners of the land, unless reference is made to their "foreign" backgrounds in Polynesia. . .

Sowell also mentions variations in attitudes towards education among immigration groups, as well as the role of families, languages, cultures and individual personalities. An interesting comment in Sowell's discussion of "ethnic identity" is as follows:

Some groups (such as the Jews and the Japanese) have enjoyed and maintained their own special culture, but without making a public issue over it (as many blacks or Hispanics have). . .

(Sowell: 295, 1981)

Probably he is referring to the social revolution of the 60's, with its theme of "Black is Beautiful," and the insistence of Hispanic groups in the United States to preserve their language and culture through bilingual education programs. The traditional "Americanization" process of assimilation and socialization to the mainstream through the efforts of public schooling was altered. Previously, through compulsory education, American schooling had managed to perpetuate the
social functions of the economic and bureaucratic systems, preaching homogeneity and conformity in exchange for upward mobility into a white middle-class society—"whether consciously or unconsciously done."— Teachers were responsible for socializing children, representing a transition from lower middle class origins to "new and painfully acquired financial status and security" (Dickeman, 1972).

Ethnic diversity was not fashionable or desirable before the 60's. The dominant, largely white society, prevailed and socialization efforts were successful, channeling leaders and blue collar workers in a synchronization of education and employment. It was a stigma to be called a "greenhorn" and not to shed ethnic characteristics in speech, appearances, and customs. Michael Novak (1973) states that "white ethnics were seldom taught that they were "ethnic." That is why the word ethnic seems to be a synonym for "minorities" --those who visibly are not melting--especially the non-white--Black, Latinos and Indians."

Novak further states the tragedy of some immigrant groups in the past allowing their names to be changed and their languages to be silenced:

How many died, how many were morally and psychologically destroyed; how many still carry the marks of changing their names, of "killing their mother tongue" and renouncing their former identity, in order to become "new men" and "new women"--these are motifs of violence, self-mutilation, joy and irony. The inner history of this migration must come to be understood, if we are ever to understand the aspirations and fears of some seventy million Americans.

(Novak: 20-25, 1974)
Some authors like Pantoja and Blourock (1976) complain that in their effort to assimilate, some white ethnics have not realized that they have been oppressed.

Hispanics and other minorities have contributed then to a reaffirmation of self-worth and self esteem in the United States. Out of the experience of the sixties, a new philosophy has emerged, safe-keeping culture and ethnic heritage while politely rejecting the "melting pot" theory. The diversity of groups in the United States is perceived now as a source of strength, not of weakness. Minorities are becoming more politically aware, as evidenced in recent political promising victories at the polls.

Teaching cultural differences and similarities is imperative. The pluralistic nature of the United States must be reflected in valid studies, adequate health programs, culturally relevant culture-oriented printed materials, and teaching strategies representing a rich and cultural diversity. Pialorski (1974) has accurately interpreted this contribution of Hispanics and other minorities by saying:

Today various ethnic groups are making it clear that they do not wish to be tossed into that rather unstable equalizer, the American melting pot. Their minority roots, buried and sometimes trampled into the soil of the North American continent, are too old. They prefer instead to enhance the contents of the pot as a cultural side dish.

(Pialorski: 3, 1974)
For an understanding of the ethnicity, culture, and language of Hispanics in the United States let us then set aside the "melting pot," and season it with the spices of our ethnic and linguistic differences and similarities. Let us make the United States a palatable banquet of diversity, and a variety of cultural, linguistic and ethnic treats. As mentioned in the Introduction, problems in communication among Anglo health providers and monolingual Hispanic patients/clients may be lessened, and compliance enhanced, by better understanding of intra-ethnic intracultural factors. Such a discussion follows under "Hispanics in the United States."
CHAPTER III
HISPANICS IN THE UNITED STATES

The first wheels that rutted the land that would become United States were Spanish.

The first horses ridden by man across the Great Plains... Also Spanish were the first oranges, lemons, limes... The first European plows and gardening tools in North America were Spanish. In fact, the first European feet to touch the shores of what is now the Southern United States were Spanish.

... from ocean to ocean, up into the heartland from the Carolinas through Missouri and Kansas to the Southwest and North along the Coast to Nootka Sound on Vancouver Island, was Hispanic. (Alford, 1972:vii)

Alford's haunting lines bring back to life the saga of the Conquistadores who brought to the newly "discovered" continent of America their language, culture, and traditions. For more than four hundred years the influence of Spain and Latin America on the language and culture of the United States have shaped the future of this country, particularly in the Southwest. Alford's work The Proud Peoples - The Heritage and Culture of Spanish-Speaking Peoples in the United States ("La Gente Altiva"), portrays those contributions of Spain and Latin America to the United States and projects a promise of rebirth of Hispanics as the second largest minority in the land.
It is difficult to forget names like Pedro Menendez de Aviles, who in 1565 founded St. Augustine in Florida; Hernando de Soto, who discovered the Mississippi River in 1541; Alvar Nuñez, Cabeza de Vaca, who explored and discovered part of Texas, New Mexico and Arizona between 1528 and 1536; Juan de Oñate, who established the city of Santa Fe in New Mexico in 1609; Fray Junípero de Serra who founded nine of the twenty-one missions established in California between 1769 and 1782, while other Spaniards founded Nuestra Señora de los Angeles de la Porciúncula (Los Angeles) in 1781.

Also, Spanish was the first European language ever spoken in the United States (Burunat, and Burunat, 1984). Therefore, when confronted by the usual demands, frequently heard in some communities, "Let them learn English," the descendants of the settlers of the southern part of this land could fairly answer, "Let them learn Spanish!"

These contributions and historical past of Hispanics in the United States must be mentioned, with the objective of developing awareness and sensitivity among Anglo care givers and educators—in particular health providers—so that the socio-historico-political backgrounds of Hispanics and the intraethic, intracultural differences and similarities among the various Hispanic subgroups may be understood.
Definitions of "Hispanic"

The term "Hispanic" derives from "Hispania," or "Land of Rabbits," a name given to the Iberian Peninsula by the Phoenicians during the Third invasion of what is now Spain and Portugal (Alonso, 1953): "Hispanics," therefore, have a common heritage with the Motherland, Spain. There are other terms used in the United States as synonyms of "Hispanics" to denote individuals of Spanish ancestry. One hears the terms Hispanic Americans, Hispanos, Latin, Latin Americans, Latinos, Spanish, Spanish-Americans, Spanish-Speakers, Spanish-Surnamed, and White Persons of Spanish Surnames. Other terms that are meant to be synonymous with "Hispanics," but are really the names of sub-groups, are: Chicanos, Meji-canos, Mexican, Mexican-Americans, Raza, La Raza, Cuban, Cuban-Americans, Boricuas, Porto Ricans, Puerto Ricans, Puerto Rican-Americans, and Ricans. The truth is that there is no standard or operational definition for the term "Hispanic" among the different agencies and organizations in the United States.

Hayes-Bautista (1980) complains about the lack of a standardized definition resulting in confusions in research studies, generating non-comparable samples, negative influences on research methodology, contamination of data for health purposes, undercounts in census-taking, legal complications with eligibility for services, and problems with affirmative
action benefits. Therefore, Hayes-Bautista urges fellow researchers to operationalize the term, "since one way to stratify society for distribution of benefits, privileges, and responsibilities has been by race and ethnicity. . . . and individuals or groups can be appropriately awarded such benefits as education and access to health care . . . ." He suggests the term "Raza," because "Hispanic" is too European. However, in the opinion of this writer, "Raza" or "La Raza" ("The Race") is not as encompassing or traditional as "Hispanic."

**Identification of Hispanics as an Ethnic Group**

As mentioned in the Introduction, different criteria have been used to identify the Hispanic group for census and other statistical purposes, such as the National Health Interview Survey (which assigns race of the father to children whose parents are of different races); the National Vital Registration System (if parents are of different races and one is white, the child is assigned to the other parent's race); or the National Survey of Family Growth (where race is classified by interviewer's observation).

Other surveys have used a Spanish surname criterion, Spanish origin, surname of head of household, birthplace of parents or self, use of the Spanish language as that spoken at home, and self-identification. Possession of any one of these criteria has been sufficient for inclusion in the surveys.
There have been problems and confusions in gathering data because of the inclusion of non-Hispanics with Spanish surnames, exclusion of Hispanics with non-Hispanic names, self-reporting varying with respondents' perception of their origin, and other complications. Only in 1976 did federal data collections specify ethnic origin—including Spanish heritage—(Health 1980: 247). Hispanics were classified as "White Persons of Spanish Surname", with a possible loss of funds and other benefits, since Hispanics are then counted as part of the general white population (Hayes-Bautista, 1983).

There was hope that the 1980 Census would have corrected some of these problems in the gathering of data on Hispanics, since emphasis was placed on ethnicity rather than on race. "Persons of Spanish origin may be of any race" (1980 Census: 3, 41). As reported by Giachello, Aday and Andersen (1983), it could be possible to make comparisons in health and socioeconomic status among the different Hispanic sub-groups as well as between Hispanics and non-Hispanics. However, up to the present time very few changes have occurred in the separation of data. It may be a slow, complicated process. Meanwhile health researchers must be careful to specify their target population, stating the criteria selected to identify the group, so that methodological errors may be avoided and comparability of findings may be possible.
Diversity Among Hispanics in the United States

In reviewing the Giachello et al article, Hayes-Bautista (1983) stresses the heterogeneity of the Hispanic population, citing several factors that must be considered, such as: education, occupation (white collar/blue collar/farmworker), rural/urban location, income class, immigration status, and acculturation. He suggests that health planners must become acquainted with those factors inherent in the heterogeneity of the Hispanic group, before proceeding with health planning and policy making. Otherwise, "they may miss the mark widely, and, in the current fiscal climate, few mistakes can be tolerated--there may not be money for second attempts" (p.276).

Recognizing the heterogeneity among Hispanics, Saylor (1979) criticizes the term "Spanish-speaking/Spanish-surnamed category" which includes Mexican-Americans, Cubans, Puerto Ricans and Latin Americans, so diverse in culture and ethnicity. She also mentions the cultural and ethnic differences that exist between the proud Spanish-Americans of New Mexico and Southern Colorado--who wish to maintain a culture identified with the Spanish "Conquistadores" in addition to their American citizenship--and are "insulted if referred to as Mexican American." In turn, the Mexican-Americans in Texas identify themselves as "Mexicanos," and have strong ties to Mexico. The Mexican-Americans from California, continues Saylor, wish to retain their cultural identity but
also wish to participate in "the American way of life."

Finally, the Chicano, a term accepted by many young Mexican Americans, "embodies the quest for equal opportunities." All these groups, explains Saylor, are considered under the "Mexican-American population," but they are quite distinct.

Furthermore Saylor strongly differentiates among the Mexican American group based on degree of acculturation (defined as "integration and participation in the dominant society") and assimilation (defined as "the act of completely moving into a society and becoming completely like that system by giving up original characteristics and values and taking on those of the new society," p. 285). It is important to remember the differentiations among the Hispanic subgroups which are partly based on degrees of acculturation and assimilation, as defined by Saylor.

Benavidez-Clayton (1979) also reminds fellow health providers of the dangers in generalizing and stereotyping Mexican Americans. Emphasizing the heterogeneity within the sub-group in the United States, she mentions differences in health beliefs, practices, language, religion, education, and assimilation. Comparing programs to a stew where a rabbit and an elephant are combined, Benavidez-Clayton states that unless cultural and historical differences are considered, inadequate health care will result. She says:

We have given lip service to "patient needs" for several decades, but when we look at the variety of . . . plans promulgated . . .
Rochelle Kelz (1982) also refers to the historical and cultural variations among the Hispanic group in the United States, which account for intraethnic, intra-cultural variations. She mentions some figures concerning the Hispanic population in the United States, and the definition of "Hispanic," as follows:

The term "Hispanic" as I use it here is a genetic label for a diverse group of Spanish-speaking people in the United States who reflect varied histories and who have a wide range of cultural values. There are over 14.6 million Hispanos in the United States, over 6 percent of the total US population, ranking them this country's second largest minority group. Estimates for 1980 for those residing in the United States illegally range from 6 to 12 million.

(Kelz: vii, 1982)

Trevino (1982) agrees with Kelz, citing a 15 million figure. That makes the Hispanic population in the United States the sixth largest in the world, exceeded only by Mexico, Spain, Colombia, Argentina, and Peru.

The Forum of National Hispanic Organizations in Washington estimates a 20 million Hispanic community, "whose
contributions and patriotic commitment to this country have too often been obscured in the past" (Bustelo: 24, 1982).

Migration and Immigration of Hispanics

While discussing the heterogeneity of Hispanics and their numbers in the United States, it is imperative to remember the complex social, political, economical, and historical factors that have influenced their unique migration or immigration experiences. The Contractor Report of November 1981, "Hispanics Students in American High Schools: Background Characteristics and Achievements," prepared by the National Center for Education Statistics, categorizes immigration and migration groups into economic and political refugees, bearing in mind the acceptance by the host population, historical circumstances in which the immigration took place, and government policies at the time of the settlement. These factors must be considered in recognizing the differentiations within sub-groups and, even more important, among individuals.

The largest Hispanic sub-group in the United States is that of Mexican descent, heavily concentrated in California, Texas, New Mexico, Colorado, and Arizona.

The second largest Hispanic sub-group is the Puerto Rican, with approximately 2.5 million, followed by 700,000 Cuban-Americans, 1 million persons of Central or South American extraction, and about 1.5 million people of "Other Hispanic Origins" (Arno Press, 1981). Furthermore, there are:
It seems that the United States is still considered by many Latin Americans a "Promised Land" ("For Hispanos It's Still the Promised Land," The New York Times Magazine, June 22, 1975). Since 1980, 500,000 Salvadorans have arrived in the United States (U.S. News & World Report, April 12, 1982). Just in Los Angeles, it is calculated that there are now close to 50,000 Guatemalans, 200,000 Salvadorans, and 2,100,000 Mexicans (Time Magazine, June 13, 1983, "The New Ellis Island"). It is estimated that legal and undocumented immigration continues yearly at the rate of close to one million individuals between the borders of Mexico and the United States (U.S. News & World Report, 1982).

Because of this continuous flow between Latin America and the United States, specially Mexico, it is important that in dealing with Hispanics an effort be made to specify a target population. By not stereotyping and generalizing among the different subgroups and individuals, bias in statistics and contamination of data in research projects may be avoided. Otherwise the perpetuation of stereotypes will prevail, aided by the media.
A typical version of Hispanics in the United States has the group linked to welfare, slums, and squalor. It is quite common to read letters addressed to the editor of local newspapers complaining about the dreaded, faceless, villainous Hispanics. Excerpts of two letters follow:

History tells us that English has been the national language of this country for over 350 years. Why is it necessary at this late date to ram Spanish down our throats... Hundreds of thousands, if not millions of people, speaking such languages as Italian, Polish, Greek, Swedish, Portuguese, German and others have migrated to this country in the past to force native citizens here to learn their language...

How can a few people change such a great country as America? What have these people contributed to this country? Why do we let them get away with so much? ... I have yet to read of anyone being punished for handling of dope although many have been arrested for possession and selling. I have read of many murders by gun or knife... I look around and see strange signs... I didn't know Spanish was going to take the place of the English Language...

(Sunday Republican, Springfield, Mass., 10/9/77)

As shocking and revolting to read, those comments to the editors of local newspapers are not uncommon. Furthermore, since newspapers are often the only "literature" read by the average American, the perpetuation of stereotypes about Hispanics continues. As professionals and multicultural educators it is our responsibility to combat those stereotypes...
and ignorant views with facts. Also this will alert the
general public, and health researchers and policy-makers in par¬
ticular to intraethnic, intra-cultural variations and similar¬
ities among Hispanic sub-groups, hopefully avoiding general¬
izations and stereotyping. Otherwise, many studies and research
in health may not be valid.

An excellent example of a good methodological approach
to intraethnic/cultural factors affecting the health of
Hispanics is that of Chesney, Chavira, Hall and Garity (1982).
In their article entitled, "Barriers to Medical Care of
Mexican-Americans: The Role of Social Class, Acculturation,
and Social Isolation," the authors warn health planners who
fail to recognize the diversity among the Hispanic sub-groups.
It is not enough to develop programs "based on simplistic
notions about 'the Mexican-American' population." Chesney
et al urge health professionals to learn about levels of
acculturation (defined as "a change of cultural patterns to
those of the host society"), social class, and social networks--
the extended family, friends, neighbors, and significant
others--before educational programs are implemented. Empha¬
sizing the rurality of poor Chicanos--the target population
studied--Chesney and fellow researchers observe that an
essential component of cultural assimilation is language,
an issue that will be discussed in the Conclusions of this
dissertation.
More studies like Chesney's et al are needed in the health field, particularly about poor, rural, young, monolingual Puerto Ricans so numerous in mainland communities on the Eastern Seabord. Providers must become aware of the problems encountered by that Hispanic subgroup in order to improve the patient-provider interaction and, consequently, health care.

Following the Chesney, Chavira, Hall and Garity anthropological framework model, Chapter IV will focus on a few health studies made on poor Puerto Ricans in the mainland as a target population. This chapter will continue discussing demographic and sociocultural factors which contribute to differences and similarities among Hispanics in the United States.

Rurality/Urbanity. Eighty-five per cent of Hispanic families reside in urban communities (Delgado, 1981). In fact, eighty per cent of Mexican-Americans and virtually all Puerto Ricans and Cubans live in urban areas (Marger, 1985). The availability of human services in urban areas seems to influence the decision of most low-income Hispanics to settle in urban areas, although their origin may have been mostly rural. Betances (1982) says that "what is often perceived as American is merely the product of industrialization; what is viewed as Hispanic is the product of a rural culture."

Age of Hispanics in the United States. The Hispanic population in the United States is young with a median age of 23, as
compared to the median national average of 31.2 (Census Bureau 1985). Thirty-three per cent of Hispanics are under 15 years of age; 20% of the Mexican-Americans and 25% of Puerto Ricans in the mainland are under the age of 9, whereas the national average is 15% (Delgado 1981).

**Fertility.** Hispanic families tend to be large, which may result in lower health utilization services per person. Also, Hispanic women are entering the peak child-bearing years, which indicates a sustained population growth among Hispanics (Giachello, Bell, Aday, and Andersen, 1983).

The National Center for Health Statistics reports that Hispanics have the highest birth rate in the United States (75% higher than the rest of the population). The report, entitled "Births of Hispanic Parentage, 1979" predicts that at the current rates of birth and immigration, Hispanics will become the largest minority before the end of the century. It further states that 8% of babies born to Hispanic women are "the fifth or later child," and that Hispanic mothers are usually younger than non-Hispanic mothers. The report states:

> Hispanic peoples tend to have larger families, with more than 8% of babies born to Hispanic mothers being the fifth or later child. ... Hispanic mothers tend to be some-what younger than white non-Hispanic women. ... The relatively large proportion of births to teen-agers among Hispanic mothers is a factor accounting for the
lower levels of educational achievement observed for Hispanic women. . . (The survey covered more than 85% of the total Hispanic population in 19 states.)

(The New York Times, 5/26/82)

Education. Giachello et al (1983) report that differences in health beliefs and health service utilization are directly related to higher levels of education and income. They further claim that 18% of the Hispanic population 25 years old and over completed less than five years of education, while 42% completed at least 12 years of education. This compares to 3% and 69%, respectively for non-Hispanics.

It is disturbing to notice that the level of educational achievement among Hispanic women is negatively influenced by the fact that there are so many teenagers among the Hispanic mothers. Tragically, a mother's schooling/education or literacy is directly related to higher fertility and child mortality rates. These "socioeconomic risks" may be preventable strategies (Mare, 1981). The role of public education in the retention of students, specially female Hispanics, is vital.

The National Center for Education Statistics indicates in the Contractor Report of November 1981 that Cubans tend to perform better on academic achievement tests than other Hispanics. The criteria used to measure achievement included educational aspirations involving three cognitive achievement scores: mathematics, reading, and vocabulary. Also, father's
education and family income were examined—called "general" vs. "specific" factors, such as timing of immigration and patterns of language use. The specific factors were only relevant to some minorities. For the three tests (math, reading and vocabulary), whites had the highest scores black the lowest, and Cubans had the highest scores among the Hispanic group. Puerto Ricans, Mexican-Americans, and other Hispanics/Latin Americans had lower scores, but still higher than blacks.

In reviewing the high scores of Cubans on the reading and vocabulary tests, the National Center for Education Statistics was at a loss to explain how Cubans, in spite of exhibiting the highest degree of retention of the Spanish language among Hispanics, were still ahead of the other Hispanic groups. A significant factor seems to be father's education. There were more fathers with college degrees among Cubans than among Mexican-Americans and Puerto Ricans. Cubans have better educational opportunities as a whole since their families are mostly members of the higher socio-economic level. They show a higher retention of the Spanish language—regarding frequency of use and proficiency—but class differences seem to influence achievement scores. The report states:

A salient feature of the table is the fact that the percentage of fathers who did not finish high school is higher for all Hispanic subgroups, although the percentage for other Latin Americans is close to that for whites. These percentages are even considerably higher than those for blacks. An intriguing result is the relatively high percentage for Cubans. This, together with relatively high proportion of
Cuban fathers with college degrees compared with Mexican-Americans and Puerto Ricans, suggests... a group with low educational achievement and a highly educated professional elite.

(p. 31)

The authors also mention the probability of other influences, such as the fact that Cubans are political rather than economic refugees; also, acceptance by the host population because of the historical circumstances in which the Cuban immigration took place. Government policies at the time of the Cuban settlement are also considered.

An interesting comment is the high standard deviation for "Other Latin Americans," which seems to indicate a high heterogeneity among the group. This heterogeneity is further stressed by patterns of nativity." Mexican-Americans show the highest percentage, with 89.4%, having spent all or almost all their lives in the United States. The percentage for Puerto Ricans is approximately 76.3%--including those individuals who were brought to the mainland at an early age. These figures show the heterogeneity of the Hispanic group because of different migration or immigration histories and nativity.

Because low educational achievement is correlated with low occupational achievement, it is important to notice that the study selected three indicators of achievement: school delay, aspirations, and cognitive achievement. (The latter
includes the three tests mentioned before.) A significant issue for Hispanics is that delayed students "may demonstrate a greater propensity to drop out of school entirely." The report indicates that among seniors, both Puerto Ricans and Mexicans have the highest rates of delay—12.6% and 9.8%, respectively. These figures are higher than those for whites (2.5%), blacks (7%) and Cuban seniors (6.4%)—the lowest delay rate among Hispanics. The report also indicates that geographical variations may mean school policies and practices harmful to Hispanics in different sections of the country. Hispanics may be penalized because of linguistic and socioeconomic characteristics.

As far as aspirations are concerned, Cubans appear to have the highest aspiration rates—even higher than non-Hispanic whites—54.9% vs. 43.6%. The Other Hispanics have similar aspirations, with percentages between 33.6 to 36.7. The report further states that Cubans are overrepresented in the two most advanced degrees: M.A. and Ph.D. or equivalent, and that this may be related to "the professional elite component of the parents of these students."

Using the 1976 Survey of Income and Education figures, the report estimates dropout rates as follows:

64%, the proportion of Hispanic dropouts leaving school between grades 10 and 12 or 24% (the total dropout rate for Hispanics) or roughly 14 percent of all Hispanics, dropouts between grades 10 and 12.
Apparently the delay rate for Puerto Rican seniors is greater than the rate for sophomores. This difference, speculates the report, may be due to the pattern of "commuting migration" between Puerto Rico and the mainland.

A significant factor that must be considered in statistics is the diversity in methodologies (estimated number of dropouts) that is adopted by the different agencies. Aspira, a leading Puerto Rican Agency in New York City's high schools, claimed a figure of 68%. That would mean that while Aspira counted the number of students moving from grade to grade each year, New York City school officials counted the number of graduates compared to the number of students enrolled four years earlier in the ninth grade. Sadly, the dropout rate for Hispanic students was calculated at 80%; 72% for blacks and 50% for whites. Gene Maeroff (1983), author of the article, stated the concern of Aspira with the impact of high school programs on children of minority groups and the interrelationship with income.

**Income of Hispanics.** Speaking about the dropout rate of Hispanics in higher education in the United States, Dr. Alonso Atencio (1980), Assistant Dean of The School of Medicine at the University of New Mexico, cites "the economic barrier as another hurdle in the path of minorities." He mentions the priorities of food and shelter over education and health for people in the lower income levels. Says Atencio, "to be poor means you can purchase less education, especially at college levels."
Giachello et al (1983) report that in 1980 the nationwide Hispanic median for family income was $14,717, or one-third lower than that of white non-Hispanics. Also, 23% of Hispanic families—one-fifth—were below the poverty level in 1980, compared to 10% of the total United States families. Cubans, excluding the latest arrivals of "Marielitos") and Other Hispanics tend to have higher levels of income and education than Puerto Ricans and Mexican Americans. The percentage of Cuban families earning over $20,000 was 41.5%, while the percentage of those earning less than $12,000 was 20.4%. That compares with 48.7% and 10.7% for whites. Mexican-Americans had the next income level among Hispanics, with a percentage of 29.5 families under $12,000. The Other Latin American subgroup's income distribution was very close to that of Cuban families, with a high of over 35.2% earning over $20,000, while 22.5% had incomes under $12,000. Puerto Ricans seemed to be the poorest group, with 48.6% of families having annual incomes of less than $12,000.

Furthermore, the Contractor Report of November 1981 states that "while the proportion of Cubans and Other Latin Americans with incomes below $5,000 is similar to that of the other subgroups, the proportions with incomes above $25,000 is roughly twice that of the other subgroups."

Therefore, without stereotyping Hispanics it may be said that, as a group, most Hispanics in the United States are poor. Although Cubans and Other Latin Americans show better
income levels, the major Hispanics subgroups—the Mexican-Americans and Puerto Ricans combined—show very low annual incomes. Obviously, this is a source of diversity among Hispanic families in the United States.

Present increases of Hispanic enrollments in schools, added to unemployment figures, indicate that the problems of Hispanics are intimately related with the welfare of the nation. Since most Hispanics are young and forming new families, it is clear that more services related to prenatal care, pediatric, young adult, family planning, teenage pregnancy, and venereal disease will be needed in the immediate future (Gianchello, Bell, Aday and Andersen, 1983; National Center for Education Statistics, 1981). Better understanding of factors affecting the lifestyle of Hispanics is imperative, particularly language.

Language. The Spanish language is a source of pride, identity and tradition among Hispanics in the United States. It gives older members of the family a sense of authority, as will be discussed later.

Compared to other languages, like Italian or French, the Spanish language emerges as a unifying force understood by all Spanish-speakers. Newly arrived Hispanics do not need English in order to be understood by members of the various Hispanic sub-groups. This was not possible among other immigrant groups. Because of different dialects within the
same country of origin, English had to be adopted among the sub-groups as the unifying language of communication in the United States.

Therefore, Anglo health care providers should learn some phrases and greetings in Spanish in order to foster better communication and health care. On the other hand committed Anglo health providers learning the mother tongue of their Hispanic patients must not become discouraged from learning Spanish because of purported "dialects" within the sub-groups. It is a fallacy that there is a "Mexican" or a "Puerto Rican" Spanish. There are regionalisms and local expressions that may cause temporary misinterpretations of terms, but that also happens with other languages, including English in the different regions of the United States. There is no reason to attribute a "purer" or more correct connotation to Castillian Spanish over the Latin American version. The differences are mostly limited to the choice of regional terms and the pronunciation of some consonants like c, j, s, and z.

The objective should be to learn "Standard Spanish," the written, official language, strictly enforced through grammatical and syntactic rules issued by the Royal Academy of the Language in Spain. Regionalisms and dialectic expressions in local communities may then be adopted for better communication.
It is actually fun to speak Spanish among the different Hispanic sub-groups--particularly the largest three in the United States--Mexican, Puerto Rican and Cuban--and to discover some terms that may not be common or even known. One of them is the term "china" used by Puerto Ricans to denote "orange." "China" means "Chinese" in standard Spanish. Imagine the confusion of non-Puerto Rican Spanish-speakers when they are told that the "chinas" are too sour! It is very important to teach some regionalisms to Anglo providers and non-Puerto Rican Spanish-speakers, since some terms may be puzzling even to native Spanish-speakers. An example is the word "guagua." In Peru, as well as in Bolivia and parts of Ecuador, the term means "baby." (It is a Quechua word, not Spanish.) I had an interesting experience while chatting with some Puerto Rican patients, most of whom had just been at the clinic. The patients explained that they were waiting or expecting ("esperando") for the "guagua" in a few minutes. I got concerned. Shouldn't they be at the hospital? They looked surprised. (At that time I did not know that the word "guagua" means "bus" for Puerto Ricans.) I made rocking motions, signaling "baby," which confused the women even more. Finally, the mystery was solved when the bus appeared and they said, "Guagua!"

A term that shows intra-language variations among Hispanics is also the word "chicha," a beverage made out of fermented corn, used in Peru and other South American nations.
In Puerto Rico the verb "chichar" means to "copulate."

Imagine the red, flushed faces of many patients at the clinic when I comment that "chicha," is a delicious treat... Puerto Ricans cannot believe that a beverage with that name exists!

**Culture**

...to know another's language and not his culture is a very good way to make a fluent fool of one's self.

(Brembeck, 1977: 14)

As Brembeck says, language and culture are intricately linked. Providers must understand this interrelationship between language and culture, since "language mirrors cultural values" (Kegley and Saviers, 1983).

In *Language, Thought and Reality* (1956) the reader is introduced to the principle of linguistic relativity, also known as the Sapir-Whorf hypothesis, linking language as an intrinsic part of culture. Whorf states that usually people perceive the world in different ways, and that language expresses those differences.

Therefore, Anglo health providers who are learning Spanish must be encouraged to learn the language through cultural expressions. Such is the case with terms used exclusively for animals or inanimate objects, but not for persons. One may say in English, "the leg of a person, the leg of a table, or the leg of a chicken." However, in Spanish only a person may be said to have a "pierna", while an animal or
A table has a "pata." Also, a person's neck is a "cuello" (neck), while an animal's is a "pescuezo." It is very common and funny to see some medical books and pamphlets that do not make those cultural distinctions. (No need to tell a person that she or he is perceived as an animal--just use the wrong term!) A well-known linguist from Georgetown University explains these distinctions in English and Spanish as follows:

A number of vocabulary items that are applicable to both animals and humans in English have separate words for animals and for humans in Spanish. . . The linguistic evidence though only suggestive, points to a difference in the classification of animal in the two cultures. In the Hispanic culture the distinction between man and animal seems very great, certainly greater than that in the American culture.

(Lado: 116, 1974)

Another cultural characteristic among Hispanics that is very important for medical records and other official documents is that of "last names"/"family names," or "apellidos." Among Hispanics of all social levels last names are treasured for generations and are hardly ever changed or "Americanized." Both last names--the paternal and the maternal--are used as last names. The maternal family name, or mother's maiden name, is actually the "last name." The paternal, or father's family name/surname, follows directly the first given name or names, like Maria Elena, or Carlos Alberto. Let us take my name as an example.
First or given names: Lourdes Nilda
Father's or paternal family's last name: Coello
Mother's maiden family name: Cueva
Full name (single): Ms. Lourdes Nilda Coello Cueva or Ms. Coello
(Mother's maiden family name: Cueva)
(After marriage the name changes by adding "de" (of/belonging to) and
the husband's last name.)
Married name: Mrs. Lourdes Nilda Coello Cueva de Delson

For brevity sake the "apellido paterno" must be used for
males and single females. If a woman is married, then her
husband's last name must be ascertained. Then the maternal
family name may be dropped or put in parenthesis. For
example, for medical records, my name would be entered as
follows:

(Mrs.) Lourdes C. Delson or
(Mrs.) Lourdes Coello Delson

Many Hispanics wishing to retain their parents' family
names are hyphenating them. Then the person must be called
by both last names. As an example, the name of a nurse-
anthropologist has been cited several times in this work:
Catherine Benavidez-Clayton. It may be that she has hyphe-
nated her parents' last names, or perhaps she has hyphenated
her husband's and father's last name. There are advantages
in using compound names, as will be explained below.

Luis Muñoz Marin, son of the Puerto Rican statesman
Luis Muñoz Rivera, is considered the George Washington of
Puerto Rico. If he were just called "Mr. Luis Marin," there
would be no way of differentiating him between his father and/
or his son, ("Junior" and "Senior" are not frequently used
in the Hispanic culture (translated as "Padre" and "Hijo"). The best way of identifying fathers and sons is by including the mother's maiden name. Following that model, it will be easier to retrieve the medical records of the many women who are called "Maria Rodriguez" in this area. Just by adding the maternal family name a permanent distinction is obtained—Maria Rodriguez Tello, vs. Maria Rodriguez Perez, vs. Maria Rodriguez Oliva, etc. Of course, the purpose is to identify the father's last name or family name as Rodriguez. The "last name" is not the family name, but the mother's maiden surname. Otherwise, there are instances where the same individual may be listed in five different ways, using five or more cards, folders, medical records or insurance documents. I have personally seen how frustrating, unpleasant, and costly the experiences of patients can become because of the mishandling of "last names." Long waits in clinics, duplications of laboratory work, unnecessary blood tests and paper work—mentioned as factors in non-compliance and faulty patient-provider interactions—may then be avoided. Therefore, Anglo health care providers must learn this very important cultural characteristic among Hispanics.

Madeleine Leininger (1979), a nurse anthropologist and a pioneer in transcultural nursing, stresses the need to educate and sensitize nursing faculty and students in the United States to the cultural and linguistic factors
influencing health behavior. Calling some current treatments "cultural impositions," contrary to the nursing profession, Leininger reminds health professionals that health care is largely culturally determined and based upon social and cultural features. She also mentions the multicultural nature of this country, advocating a humanistic nursing model that stresses the importance of understanding differences in perception among ethnic groups.

Berry, Kessler, Fodor and Watto (1980) also state the need for more training of providers in the cultural backgrounds of their clients. In their report on intercultural communication for health personnel, Berry et al mention communication differences between Anglo providers and Hispanic patients not only due to linguistic barriers, but to lack of cultural understanding. They say:

While language differences between patient and practitioner may cause misunderstandings, other communication differences may also be present. . . the ethnocentric attitudes of the Anglo practitioner may affect the Hispanic patient's perception of the health care environment. . . The lack of interpersonal conversation with Anglos as compared to Latinos may be perceived as impersonal and may be insulting to the Latino.

(p. 3)

This cultural characteristic for personalization among Hispanics and other minorities, particularly rural people (Green, 1982; Saunders, 1954; Badillo-Ghali, 1977; Valdez and Gallegos, 1982; Harwood, 1981) may be reflected in
appointment-breaking and the underutilization of certain health care facilities. Anglo health providers may appear aloof, distant, and impersonal. Thus, the patient-provider interaction is affected. (This need for personalization in health care is further discussed under the section on ethnicity and the Puerto Rican family in the mainland.) A need for understanding this cultural trait, particularly among behavioral ethnic Hispanics, is stressed.

Vacc and Wittmer (1980) express the responsibility care givers have of knowing the cultural background of their clients as follows:

Love and empathy are not enough! . . . helping professionals must make a concerted effort to understand cognitively the different subgroup members found among their clientele; an understanding that is over and above affectual understanding. . . A lack . . . makes one more prone to impose one's own values. . . Helpers with a sound cognitive knowledge of their client's cultural background will more easily understand the source and reasons for the behaviors which may appear odd or even peculiar at times.

(pp. 6 and 7)

Alan Harwood (1981) also recommends "ethnically appropriate health services, personalized, more culturally oriented health care to patients of different cultural backgrounds" (p.1). Furthermore, Harwood states that part of every patient's lifestyle is determined by his/her cultural background, which in many cases derives from ethnic heritage. He urges health professionals to become familiar with the
patient's ethnic background, since food preferences, pain responses, perception of symptoms, and care-taking responsibilities are likely to be influenced by ethnicity.

Ethnicity


Behavioral ethnicity, says Harwood, is observed by first and second generation individuals and by ethnic minorities "with a history of systematic exclusion from mainstream educational institutions and positions of political power--most notably blacks, Hispanics, and Native Americans" (p.6). He emphasizes a relationship between behavioral ethnicity and poverty.

Ideological ethnicity, says Harwood, draws those individuals largely from third and fourth generation whites who in most situations "behave indistinguishably from others of the same class and regional background as themselves--renovating their cultural heritages and emphasizing cultural autonomy" (p.7). That is, ideological ethnics observe the celebrations of some holidays, eat certain special foods, use some phrases or words from the language of their families while speaking English, and other adaptations of the "old culture." Those are more voluntaristic than behavioral ethnic traits.
The importance of Harwood's differentiation between behavioral and ideological ethnics is that in the case of ideological ethnics the behaviors are not crucial to their existence, since they are by choice. In contrast, the behavioral ethnics—mainly the first and second generations—usually experience "culture shock" or trauma in their lives, while painfully acculturating to their new surroundings, new languages, new social networks, attitudes and traditions. This, of course, is directly related to the situation of most Hispanic poor in the United States. Ethnicity and class are, therefore, closely related and should both be considered in dealing with problems of behavioral ethnics. Harwood explains the relationship between ethnicity and class as follows:

Though analytically separable, ethnic and class phenomena are in reality closely interrelated in the United States, as in any stratified society. . . Within the larger American social system, some ethnic groups are to a significant degree confined to lower-class positions because of barriers to both power and economic resources. . . few would deny that blacks, Native Americans, and Hispanics in the United States disproportionately occupy the lowest strata of the class system and have historically been restrained within these strata by legal and economic means. . .

(p.5)

A result of this synergistic effect of behavioral ethnicity and a lower socioeconomic status may be observed in the attitudes of many Hispanic patients towards authority figures, expressions of emotion in asking for help, extreme
modesty, hesitancy in discussing sexual matters with health
providers of the opposite sex, popular and folk-health
orientations, and more tolerance towards such indicators of
distress and disease as swelling, bleeding, and pain
(Knutson, 1965; Henderson and Primeaux, 1981; DiMatteo and
DiNicola, 1982; Harwood, 1981). These perceptions must be
understood by health providers in considering class as a
variable.

Social Class

Social class divides Hispanics in the United States, a
fact that is not discussed openly for fear of being labeled
snobbish. However, class is an issue well recognized in
public health. The poor are affected by higher rates of
infectious disease, higher infant mortality, hypertension,
stress, and are more vulnerable to illness than the rest of
the population (Simmons, 1958; Quesada, 1976; Smith, 1979;
Syme and Berman, 1979; Harwood, 1981; Ablon, 1981; Starfield,
1982). The lower socioeconomic status of most Hispanic
families in the United States has serious implications for
health care. Studies on Hispanics of the lower socioeconomic
levels indicate that their perceptions of pain, symptoms,
severity of illness, and expectations of providers are dif-
ferent than those of the middle and upper classes (Quesada,
1979; Canino and Canino, 1980; Fernandez-Pol, 1980; Harwood,
Educators and care givers must be aware that social class differences exist in Latin America. It is unfortunate, but a class-conscious structure exists. The society is arbitrarily stratified into three social classes: upper, middle, and lower. Each of those classes is again subdivided into upper, middle and lower. This diversity in class is reflected among Hispanics in the United States too, and it has been described as follows:

They may be Castillian Spanish, or Caribbean island black, or Spanish-Indian mestizo. Among them are Cubans who fled to the U.S. with money and middle-class skills, improved Puerto Ricans or Mexican Americans looking for a job--any job; aristocratic Spaniards, whose families settled in the Southwest before the "Mayflower" hove into Plymouth Harbor. . .

(\textit{Time}: 48-61, 10/16/78)

Because of these intraethnic, intraclass differences, there are more commonalities in the lifestyles of middle-class Hispanics and middle-class Anglos than among middle-class Hispanics and lower-class Hispanics. These differences and similarities among Hispanics and Anglos in the United States have been mentioned in the local press as "news."

An article entitled, "Latinos' Lifestyles in the U.S. Similar to Natives," states:

"An educated, upper-class Hispanic has more in common with an educated, upper-class American than with a lower-class Hispanic," said Marcelino Miyares, president of a leading minority advertising firm in Chicago. "Poor people have a tough time, no matter whether they are male of female, white or Hispanic. . . ."

(\textit{Archy Obejas, Springfield Daily News}, 10/23/82)
In other words, class transcends nationality, ethnicity, and color. Providers must become aware of class differences among Hispanics. Many individuals requiring social and health services are members of the poor working classes whose linguistic and cultural barriers are compounded by illness and unemployment. This does not mean, however, that just because people are poor they will behave as "lower class"; individual characteristics must be considered. Some generalizations are necessary to understand differences in perceptions, health values and practices; but individualizing health care must be the objective of responsible providers. Ozzie G. Simmons, the author of an article considered a classic in the health field, explains this important issue as follows:

When class value differences are discussed in terms of middle-class and lower-class, the reference is to modal types which higher and lower status people may manifest in different degrees; it does not necessarily follow that all higher status people adhere to middle-class modal type, and lower status people to the other.

(Simmons, 1958: 100)

Simmons' words lead to the discussion of the socio-cultural and linguistic conflicts mentioned in the Introduction of this work. A difference in class between Anglo health providers and Hispanic patients or clients has been blamed for much of the problem. With due respect to many distinguished authors (Branch and Paxton, 1976; Roter, 1977; Rund and Krause, 1978; Leininger, 1979; Smith 1980; Harwood,
Anglo health providers are not always middle-class while their Hispanic clients and other minorities are always lower class. There are class differentiations among minorities as well as within the mainstream majority. By association, and by sharing some beliefs and values, not by "origin," most health providers identify with middle-class values. Navarro (1976) explains these differences in origin vs. association or sharing of beliefs, as follows:

In a class society, it is just "natural" that those in positions of power belong, for the most part, to the capitalist class, either by association, or the sharing of beliefs.

(p. 444)

Therefore, while undertaking their training many health professionals and paraprofessionals adopt middle-class values; but they do not automatically become members of the middle class. Many of these providers are children of behavioral ethnics, sharing common problems and idiosyncracies with low income Hispanic patients and their families. It is imperative, therefore, that health providers and educators become familiar with their own ethnicity and familial roots before attempting to help others. A sensitivity to patients' feelings may only occur if providers undertake an introspective examination that will avoid the "cultural blindness" and "ethnic amnesia" mentioned in the Introduction of this dissertation.
Murillo-Rohde (1979) stresses the importance of understanding individual and sub-group characteristics among Hispanics, particularly the factor of social class, as follows:

To provide effective and safe care to Spanish-speaking consumers we must take into account culture, language, values, and belief systems differences, as these affect health and illness perception of Hispanics. Spanish-speaking people also perceive health care providers in specific ways. The socioeconomic and educational level of people within the same ethnic group provide the individual with different perceptions of the same values and cultural beliefs.

(p.226)

That quotation serves as an introduction to illiteracy among Hispanics, a critical factor in health.

**Literacy/Illiteracy**

It is hard to believe that there are around twenty to twenty-five million functionally illiterate adults in the United States (Kozol, 1980; Hunter and Harman, 1979; Cook, 1983) who are unable to read, count, and/or comprehend written materials. These individuals are too ashamed, intimidated, or discouraged to ask for simpler instructions, explanations and help. Kozol explains this predicament as follows:

Men and women cannot realistically be expected to survive within this social system if they cannot read and understand those forms of admonition that relate directly to their health and safety. . .of
access to health care and some basic comprehension of the medical vocabulary, especially the type of words that tend to mystify the patient while intimidating those who wish to question why a certain procedure or particular medication has been recommended.

(Excerpts)

With monolingual Hispanic patients/clients, illiteracy is compounded specially when individuals are illiterate even in their own language. The limited vocabulary of the Hispanic patient, added to the stress of the clinical encounter, may prevent an illiterate or functionally illiterate individual to understand the health provider's instructions or explanations. Attempting to correct the situation, the hospitals and other health institutions resort to audiovisuals. From personal experience I must recommend caution in using English versions of health education materials to inform monolingual Spanish-speaking patients. People's perceptions are influenced by their past experiences as well as their environment. Non-verbal communication may be hampered by culturally perceived experiences, particularly with illiterate individuals. The following incident happened to me with a well-respected but functionally illiterate folk-healer from the local Puerto Rican community. We had met again at a neighborhood health fair and were invited by a social worker to view a short film on breast self-examination. The film was in English, and the lady folk-healer ("curandera") only spoke Spanish. At the end of the eight-minute
film, I asked her what she thought of the movie. She politely answered, "These Americans are really smart! They get rid of the cancer by squeezing it through the nipple." I was horrified at her perception of the procedure as "squeezing out" deadly matter. Knowing that this lady is a reputable traditional healer and a respected member of her community (without her advice or approval many patients refuse hospitalization or treatment), I carefully but firmly corrected her opinion as to the preventive, not curative, nature of the film. The social worker, who spoke some Spanish, was very puzzled and surprised by these developments. It was truly an excellent lesson in health education for all of us.

When I finished my explanation, my lady friend lifted an eyebrow and stated, "Of course you don't cure cancer like that; you just feel all around your breast. Then, if a 'bolita' (a small ball or lump) is found, you must tell the doctor. Don't forget that, dear, for your own information!"

I thanked her and hurried to say good-bye, hoping that Hispanic patients will benefit from her accurate version of the breast self-examination presentation.

It is obvious that a need for qualified bilingual, bicultural health workers is critical. The alternative is competent bilingual, bicultural translators. Also, the preparation of culturally-oriented resource materials is important for improving patient health care. These are strategies
designed to improve the patient-provider interaction, mentioned in the next Chapter, under the Puerto Rican Family in the Mainland. A brief reference to the role of the Hispanic family follows.

The Hispanic Family and its Influence on Health Beliefs and Practices

The Hispanic family, regardless of social class, is patriarchal and extended. Kinship is bestowed to blood relatives as well as to "compadres"—ritual kinship—(co-parents). Valdez and Gallegos (1982) explain this concept of family among Hispanics as:

. . . the notion of familia extends beyond blood lines and effects a community spirit. The extended family (together with the helping network) is formalized through the religious ceremony of godparenting. Grandparents, uncles, aunts, and cousins are all members of an immediate support system. The role of "comadre" or "compadre" (friend and confident) further extends this network.

(p.202)

The family controls the individual with love and care through the magic of language and cultural traditions. There is no stigma in being interdependent of the family among Hispanics, particularly when health decisions are involved. Health is a family affair. This cultural trait must be understood by well-meaning Anglo providers when discussing independence, decision-making, and "the right to choose," with Hispanic patients. Green (1982) has referred to this influence
and control of the Hispanic family over the individual as "the role of the family an their precedence over individualistic concerns."

Particularly among the poor, Hispanics fear separation from the family and significant others. This is reflected in the numerous visitors surrounding Hispanic patients in medical settings, specially when hospitalized. Explanations of regulations limiting just two visitors at a time seem to fall on deaf ears. Providers must understand the fear of relatives to leave the patient alone, without the emotional and physical support of relatives and close friends. The relatives cannot understand that they are disrupting hospital routine. They must be informed gently that other acculturated Hispanics and non-Hispanic patients may prefer less people around them, in closed quarters, while being hospitalized. However, providers must understand that group decisions are customary, since the patients, being mostly poor, must rely on family and friends for funds and services to relieve them of daily tasks and normal obligations. If pressed for immediate decisions, many of these patients will politely listen "and agree in name only in order to be courteous and to avoid dissension" (Kelz, 1982). Of course, this is not solely a characteristic of Hispanic patients, but as a rule, there is a desire for politeness towards authority figures and self-sacrifice is expected of all family members (Quesada, 1976).
Just as it is considered wrong not to visit and stay for a while with a sick member of the family, it is against cultural values to place elders in nursing homes. In Latin America the concept of nursing homes is almost unknown; and this cultural trait is also observed among most Hispanic families in the United States, regardless of social class. Benavidez-Clayton (1979) suggests that perhaps an "exemplary strategy" exists among Mexican Americans, the largest subgroup of Hispanics in the United States that may be emulated by the rest of Americans. Of the one million residents in American nursing homes, Benavidez-Clayton reports that 96% are white, 2% are black and 2% "all others" (Asians, Native Americans, Mexican Americans, etc.). The implications for health planning and programming are that before arrangements are prepared to establish nursing homes for Hispanic residents, this American culturally irrelevant custom has to be considered. Instead, it is more practical and logical to provide for better and larger housing for the traditionally large and younger families of the Hispanic poor in urban areas of the United States.

As has been mentioned before in other sections of this paper, the Hispanic group is young in the United States with a median age of 23, as compared to the national average of 31.2. (In the case of the Puerto Rican subgroup, the second largest Hispanic representative in the United States, the median age seems to be 19.4 years old.) As the population grows older
and more acculturated, perhaps there will be a change and cultural expectations will show a need for nursing homes. However, it seems quite remote that the Hispanic family will decide to place its elders in institutions. It is better to invest funds in education, employment retraining, housing, and health care than in culturally irrelevant nursing homes.

A more detailed discussion of traditions observed in Hispanic families will be offered in the next Chapter, under "Puerto Rican Families in the Island" and "Puerto Rican Families in the Mainland." The role of the family is cited as one of the factors influencing health. At this time it must be mentioned that the link between rejection of traditional Hispanic family values has been responsible for mental health problems among some Hispanics in the United States. It seems that the behavioral ethnic (discussed under "Ethnicity in p.102) have fewer incidents of mental health problems. Blanca Fernandez-Pol (1980), commenting on the link between acceptance of traditional Latin American family values and the development of psychopathology, suggests that the observance of family values among poorer Hispanics protects its members. Since strict role definitions prevail among the traditional Hispanic families, particularly among the members of the less affluent groups, the conflicts of Americanization of the family and consequent role reversals—caused by migration and stress—seem to be responsible for severe mental health conditions. Understanding
the influence of traditional family roles among Hispanics will equip Anglo providers to offer better health care.

Reference should also be made to the cultural practice of using both the paternal and maternal family names as the "last name" of Hispanics. This cultural trait has been discussed before as the source of pride among families. However, it is important that Anglo providers understand that the practice of determining relatives by factual kinship may be misleading among Hispanics. Therefore, before a decision is taken in hospitals as to the legality of a visit or a signature from close or "legal" family members, efforts should be made to understand close family ties. As was explained at the beginning of this section, the "compadre" system, or the ritual of "compadrazgo," converts a close, intimate friend into a true family member and "significant other," with all the privileges and commitments of a blood relative. The "madrina" (godmother) and the "padrino" (godfather), chosen by a child's parents to represent them as "co-parents," should, therefore, be acceptable as legal representatives of a child, with all the duties and responsibilities expected of the biological parents.

In closing this section on the Hispanic family, it is important to remember that in terms of health values, beliefs and practices, the mothers and grandmothers are usually the healers. Naturally, that includes the "comadres" (the children's "madrinas" mentioned above). In most Latin American
homes, particularly among rural populations, herbal medicine may be practiced. With the shift of populations to urban areas, traditional/folk medicine has also expanded to cosmopolitan areas. Although there are many Hispanics in the United States who do not practice folk medicine, it may be fair to say that most individuals from the various Hispanics subgroups are familiar with home remedies, laxatives, poultices, herbal teas and other family concoctions.

With the active flow of population exchange between Latin America and the United States, added to the strong ties among Hispanic families, it is natural that folk beliefs, values and practices are present. Depending on degree of assimilation, social class, and family traditions many Hispanics observe folk medicine practices. However, because of the intraethnic, intracultural differences and similarities discussed previously in this paper, providers should not assume that the same health practices are exhibited among all Hispanic subgroups. Harwood (1981), Murillo-Rhode (1979), and Bulloughs and Bulloughs (1982), mention the extended use of "curanderos" (folk healers) among Mexican Americans of the poorer classes, while the same population among Puerto Ricans prefers "espiritistas" and "mediums." Henderson and Primeaux describe Third World medical beliefs and practices as "less compartmentalized than that of modern Western people."
explaining their illnesses in terms of imbalance between the individual and his or her physical, social and spiritual worlds" (p. 61). These authors describe "espiritismo" as "the belief that the visible world also includes an invisible world inhabited by good and evil spirits who influence our behavior" (p. 66) and that spirits make their presence known through mediums. Furthermore, Henderson and Primeaux mention the role of mediums as:

Mediums treat both emotionally related and physical illnesses. Unlike Western-based approaches to health, Third World cultures (Africa, Asia, and Latin America) do not distinguish sharply between physical and mental illness. Consequently, mediums treat the whole person. For example, in Puerto Rican culture psychological symptoms are frequently expressed as somatic illness. Mediums do not ignore such complaints but instead take for granted their dual nature.

(p. 66)

The effects of familial roles, ethnicity, social class, and folk medical practices in the families of Puerto Ricans in the mainland are further discussed in the next Chapter.

The last reference to family practices and folk beliefs and values must include the hot and cold theory of disease, mentioned throughout the literature concerning the health of Hispanics. This theory is traced to the balance between the four humours (phlegm, blood, black bile, and yellow bile), also known as the "humoral theory." Illness is said to be caused by imbalance among the four humors. The theory was car-
ried from Spain to the continent of America and blended with local health beliefs. Although the theory seems to have disappeared in Spain, it is still prevalent in many Latin American countries. The dichotomy of hot and cold has prevailed. A very important revision of the custom is cited throughout the literature as extending the practice to foods and medications (Harwood, 1971). Unfortunately, there seems to be no consensus of opinion among the different communities and individuals of Hispanic heritage about the properties of the hot and cold nature of foods, diseases and medications. More research is necessary because of its implications for public health measures and patient health care, bearing in mind individual differences. Further discussions on The Hot and Cold Theory will be found in the next Chapter, "Puerto Ricans in the Mainland and the Island," and in Chapter V, the Descriptive Study. It is hoped that this Chapter on Hispanics in the United States will aid in sensitizing health providers, improve the patient-provider interaction, and foster quality care.
The Puerto Rican's late entry into a post-industrial society has engendered an atypical situation of marginality. His journey from accommodation to assimilation must occur in a technological and automated environment. He must adjust from an agricultural, rural, socio-psychological type of thinking to an urban technologically-oriented type of thinking. The transition is slow and all obstacles are viewed with suspicion and hostility.

(Vasquez and Bahn, 1974:106)

Much has been written about the plight of the Puerto Rican poor in the mainland—the United States—and of their struggles and pain in the difficult process of acculturation, from a mostly rural/partly urbanized society, to a fully industrialized environment in the mainland.

As was explained in the Introduction of this dissertation, the purpose of this work is to help providers become more aware of the factors affecting the health of Hispanic patients/clients, particularly monolingual Puerto Ricans in local communities. This may foster better communication among patients and providers and improve health care. Some important factors/barriers affecting the health of Puerto Ricans and preventing compliance will be discussed, such as: culture, language, education, ethnicity, income, migration, acculturation, socioeconomic status (poverty) and color.
In addition to those factors, there will be a discussion of perhaps the most salient one: the family. A brief review of the historical background and geographic position of Puerto Rico will precede those discussions in order to acquaint health care providers with the Island and its people.

**Geographic and Historical Background of Puerto Rico.** Puerto Rico is a small island in the Caribbean, part of the Greater Antilles, and the smallest of the group composed by Cuba, the Dominican Republic, Haiti, and Jamaica. It measures about 100 miles in length by 35 miles in width—approximately the size of Connecticut—with a land mass of about 3,500 square miles. It is densely populated—800 hundred persons per square mile, as compared to Japan's 700 and 60 for the United States (Dateline Puerto Rico, Winter 1983.) The population of the island is approximately three million people. The capital is San Juan, founded by Juan Ponce de Leon and incorporated in 1511 as the second oldest city in the New World.

Columbus arrived in the Island of Puerto Rico on November 19, 1493. At that time, the region was inhabited by the gentle Taino Indians who were easily conquered and mistreated by the Spaniards. Most were exterminated. The few that survived intermingled with the conquerors or fled to
the mountains. This is now remembered as "the flight of the Jibaro." ("Jibaros" are the peasants of Puerto Rico.) The term is becoming a source of ethnic pride on the island (Burdette, 1976). A vestige of that historical past is present in some words of Arawak (the Taino language) origin, such as "huracan" (hurricane), "hamaca" (hammock), and "canoa" (canoe).

The Spanish conquest lasted from 1493 until 1898, influencing the language, culture, identity, and, especially, the structure of the Puerto Rican family. During that time, since the Taino Indians were decimated, African slavery was instituted in Puerto Rico and was only abolished around 1873. Intermingling occurred, with cultural exchange of foods, rituals, music, and other traits (Burdette, 1976).

Following the defeat of Spain in 1898, Puerto Rico became part of the United States as a result of the Spanish-American War, as mentioned before. In 1917, Puerto Ricans became American citizens, and in 1950, Puerto Rico became a Free Associated State (Estado Libre Asociado)—"neither fish, nor fowl"—a position it holds at the present time. In other words, it is a colony of the United States with "commonwealth" status.

The unique position of Puerto Ricans as American citizens and the proximity of Puerto Rico to the mainland allows them to travel back and forth without restrictions.
This has resulted in a "cultural flow" that has families living part of their lives in both the island and the Mainland. This commuting pattern, mostly of families from rural areas "via urban slums" (Rivera, 1974), has been called "the Puerto Rican diaspora," and is responsible for increased ethnic ties with the island and the maintenance of the Spanish language as a very strong link among families. Unfortunately, while the "diaspora" lessens the cultural shock experienced by migrants, it has also acted as a barrier, by preventing Puerto Ricans to become more attuned to the American mainstream, as in previous immigration waves. Thus, the Spanish language, a source of identity and pride among Hispanics in the United States, may be acting as a barrier by preventing upper mobility of the monolingual Puerto Rican poor, decreasing their chances for employment, education, and health. These problems will be examined shortly.

Income in Puerto Rico. The economy has been gradually deteriorating in Puerto Rico, with a reported per capita income of about $3,000 a year (The Morning Union, November 27, 1981), or one half that of Mississippi, the poorest state in the nation (The New York Times, August 10, 1982, "An Urgent Debt to Puerto Rico"). Sixty percent of the population is on foodstamps, while the cost of living is 8.2% higher than in Washington D.C. (The New York Times Magazine, July 3, 1983).
Unemployment in Puerto Rico. Reports of 24% unemployment—around 250,000 jobless—demonstrate a critical situation. One out of three workers is employed by the government and lately thousands of government workers have been laid off (The New York Times Magazine, August 3, 1983). Unfortunately, unemployment is reported as high as 40% among some age groups (personal conversations with Puerto Rican professionals in San Juan, Puerto Rico, January 1983).

Migration to the Mainland. Because of shattered economic conditions on the island, more and more Puerto Ricans are migrating to the mainland in search of better health, educational, and work opportunities. This pattern is not new. There is a definite correlation between the migration from Puerto Rico and job opportunities in the mainland. When there is high unemployment in the mainland, there is reverse migration to Puerto Rico and vice-versa (Badillo Ghali, 1977). However, this time the situation seems to have worsened. A new exodus, apparently from members of "the new middle class" in Puerto Rico, is occurring now ("The New Wave of Puerto Rican Immigrants," The New York Times Magazine, July 3, 1983).

It is imperative that health providers in particular keep abreast of these new developments in Puerto Rico, since unemployment, migration, and the disruption of the extended family roles—added to the stress of a different
cultural and linguistic environment—critically influence the health of Puerto Ricans in the mainland. A discussion follows identifying factors affecting the health of Puerto Ricans in the mainland.

Factors Affecting Lifestyles and Health of Puerto Ricans in the Mainland

The Puerto Rican family finds itself in a hostile environment which makes life a struggle for existence at every turn... finds itself defined as a minority group, whereas in Puerto Rico it was a part of a majority. "Minority" is synonymous with an out-group whose worth, culture, values, and life-styles are depreciated... with blocked access to the fraternity of the in-group and the full benefits of the American way of life.

(Mizio, 1974: 79)

Emelicia Mizio's words serve as a very adequate introduction to the understanding of factors affecting the health of over two million Puerto Ricans in the mainland. In order to understand the problems faced by the migrants, it is very important to realize that there are differences in the term "Puerto Rican, as defined by the different institutions in the United States, particularly while gathering health data. The most helpful publication in this regard has been compiled by Jose Oscar Alers (1978) on the health of Puerto Ricans in New York City. Since close to one-half of the total population of Puerto Ricans in the mainland is concentrated in New York City, these findings are invaluable.
Definitions of "Puerto Rican" in the Mainland and Health Data

Just as in the case of the term "Hispanic," there are conflicts in the definition of the term "Puerto Rican." Terms such as Hispanic, Spanish-Speaking, Spanish-Surnamed, Spanish-American, Latin, and even "Minority" are used to describe the Puerto Rican population, lumping them with other Hispanics (Alers, 1978). These differences in definitions result in contaminated data for health purposes. Besides, statistics are not clear when the U.S. Census Bureau uses the definition of "Puerto Rican" to include only a person of Puerto Rican birth or parentage (eliminating persons in the third and subsequent generations who still consider themselves Puerto Rican and/or are so defined by the general community). On the other hand, the New York City Health Department uses two different ways to collect data. That is, within the New York City Health Department, statistical information on Puerto Ricans is compiled by parentage for infant mortality, birth, and premature births, while mortality rates include only those born in Puerto Rico. These differences in compiling statistics, added to the confusion of the different terms used to define Puerto Ricans, represent variations that affect the validity of statistics on Puerto Ricans. The confusion is also present in the way the Narcotics Register of New York City compiles statistics on drug abuser, since they use the term "Hispanic" when referring to Puerto Ricans. Alers says,
It is not at all clear, however, that the Register's report of a person as "Hispanic" follows the U.S. census definition. This could greatly affect the reported rates for the Hispanic group. . . . Whether or not one takes the Hispanic figure as the true rate for Puerto Ricans (who constitute about two thirds of all Hispanics), it is clear that there is a vast gulf in the rates of the minority groups and those of the whites.

(pp. 23-24)

The differences in definitions and compilation of data are incomplete, deficient, and biased, as will be seen from other examples.

The data on mental illness and retardation by racial/ethnic group for New York City are available from records kept by the New York State Department of Mental Hygiene. An admission form is completed for each individual interviewed. There is an item in the form indicating the racial/ethnic group of clients, with special codes for Puerto Ricans, blacks, whites, "others," and an "unknown" category for those persons whose racial/ethnic group is not stated. A person is considered Puerto Rican

. . . if he or a parent was born in Puerto Rico, thereby including both first and second generation Puerto Ricans. If a person is classified as Puerto Rican by these criteria, he is defined as such whether he is white or black. Racial/ethnic identification is determined on the basis of observation or the statement made by the patient or client.

(p. 15)
Also, the admission form requires that personnel fill out an item indicating "their initial or working psychiatric diagnosis or impression of the client at the time of the interview." This means that both times—in the racial/ethnic identification item and in the initial or working psychiatric diagnosis item—it is up to the interviewer's perception of the client how an individual is categorized. This places a tremendous responsibility on the interviewer, and the possibilities for biased data, particularly if providers and clients have different linguistic and cultural backgrounds. In the case of monolingual Puerto Ricans completing questionnaires, with hardly any command of the English language, it seems unfair and even ridiculous to follow such a procedure. Data gathered in this way must certainly be subjected to close scrutiny. It is, therefore, significant that under those conditions "total admission by racial/ethnic group show that the rate per 100,000 population for both Puerto Ricans and blacks is approximately twice the comparable rate for whites" (Alers:16).

It is also important to notice that racial/ethnic identification is determined on the patient's self-report, which means that the client's self-classification does not always coincide with that of the interviewer. Also, it may mean that third and fourth generation Puerto Ricans are not considered Puerto Rican any more. All this confusion may be responsible for the "devastating picture of mental illness and retardation experienced by blacks and Puerto Ricans in
The disturbing point here is that conflicts between providers and clients seem to be aggravated by allowing subjective questions to exist when gathering data. Even with highly trained, sensitized health workers, with adequate case loads, it would be difficult not to expect mistakes or poor judgments. The danger of labeling people "retarded" or "mentally ill," secluded in institutions alien to their real needs, is very real.

In the case of Puerto Rican monolinguals who are interviewed and diagnosed mostly by English-speaking providers—due to the shortage of professional bilingual/bicultural health personnel—the implications of biased and/or invalid data leading to improper diagnoses are awesome. Specially in the area of mental health, understanding the language, culture, and personal background of patients/clients is a critical factor.

Aler's voices those concerns when he says:

It is difficult to conceive of a systematic explanation of these figures and others presented in the discussion of mental illness and retardation that does not stress the economic, cultural, and, especially, the linguistic differences between Puerto Ricans and the other two groups and contrast them with the characteristics of the staff personnel who diagnose the clients admitted to these facilities.
Having been introduced to the various definitions and data gathering procedures in New York, and the urgent need for better prepared health care professionals and paraprofessionals to serve the Puerto Rican community, it is important to remind providers that not all Puerto Ricans face the same problems, nor are their needs the same. There are intra-ethnic, intracultural differences—just as in the case of Hispanics—the main group in the United States—described in the previous Chapter. Those differences affect health behavior and utilization of services. A discussion of factors affecting the health of Puerto Ricans in the mainland follows.

Age. The median age in 1980 was 19.4 years old for Puerto Ricans, as compared to 28.6 years old for the total United States population. More than three-fourths of all Puerto Rican families have children under 18, as compared to only one-half for all other families in the United States. One fourth of Puerto Ricans in the mainland is under 9 years of age (Harwood, 1980). This means that the Puerto Rican population in the mainland is young, with distinct needs for services like schooling, accident prevention, health insurance, family planning, housing, welfare, and alcohol, drug, nutrition, and sex education—among others.

Lead poisoning is a leading health problem among young children. The Findings from New York City state that around 450,000 apartments, with approximately 20,000 children need better control measures. Since lead poisoning is connected
with mental retardation in children and the condition is preventable if adequate measures in interior housing surfaces are observed, Puerto Rican communities in the mainland must consider this condition a priority.

Another important finding mentioned by Alers is that Puerto Rican children under 15 have a higher mortality rate from influenza and pneumonia than the general population. Also, the rate of accidents is high in this age group, accounting for 28% of all deaths. It is, therefore, not surprising to learn that the medical specialties most sought after by Puerto Ricans are pediatrics and obstetrics/gynecology. However, there does not seem to be enough representation of health professionals/paraprofessionals with bilingual, bicultural ability to cover this need.

Also important to note is that death from cancer and cardiovascular disorders is lower in the Puerto Rican community in New York because of the relatively young age of the group. What is tragic and very feared is the epidemic of drug dependence, with a high prevalence of 50% of Hispanic addicts reported under the age of 25 (Alers, p. 84).

It is imperative that health providers consider these disorders and conditions observed and reported in the study of New York City Puerto Ricans, which may also affect local communities.

In Springfield, Massachusetts, the first major study of Puerto Ricans, released on October 30, 1978 by the Spanish
American Union, indicated that the median age of Puerto Ricans in Springfield was 14.7 years, vs. 29.1 years for the general population of the state. Also, 82% of the households had children under the age of 5 years. Approximately 51%, or one out of every two Puerto Ricans, was below the age of 14 years, as compared to 25.5% for the same category in the general population of the state. Also, 63% fell below the age of 20 years, as compared to 36.6% for the general Massachusetts population. Only 28.7% of the population fell under the 25 to 64 age category, as compared to 43.98 for the general population. That is the age considered as the prime working period of life.

A significant figure is the one related to the age category of 65 years and over. While 11% of the general Massachusetts population was over the age of 65 years in 1970, the proportion of persons in the 1978 study was less than 1%. The implication is that while the proportion of individuals 65 years old and over is growing in the United States, Puerto Ricans will not reach that age, as a group, for a few decades.

With lower levels of educational attainment and larger-than-average families, Puerto Ricans are at a disadvantage. This is shown in their income.

The National Center for Education Statistics, 1981, reports that 48.6% of Puerto Rican families have annual incomes of less than $12,000—the lowest income within the Hispanic group. (See last Chapter No. V, "Hispanics in the United States.")

Canino and Canino (1980) and Badillo Ghali (1977) cite a figure of 33% of mainland Puerto Ricans living below the poverty level, as compared to 12% for the general population in the United States.

In Springfield, Massachusetts, comparative figures were difficult to obtain. Table 17 (p.63 of the Spanish American Union report) shows a mean yearly income of $7,182.76 for males and $6,131.05 for females, and a median yearly income of $6,760 and $5,226, respectively. Because unemployment rates in the area were between 25% to 50% for men, the report indicates that the income of Puerto Ricans in Springfield is much lower than for the general population.

The above figures confirm the fact that most Puerto Ricans in the mainland are not only young but also poor—a lethal combination—which makes it imperative for the nation to revise present programs and services. One of the most important areas that needs reorganization is, of course, education.
Education in the Mainland. As mentioned in Chapter III, Puerto Ricans in the mainland have the lowest educational achievement scores and the highest dropout rates of all Hispanic subgroups in the United States. These low scores and high dropout rates seem to be connected with "commuting patterns" (to and from the island and the mainland) and also to deficiencies in the English language.

In Springfield, the level of education of Puerto Ricans in relation to the general population in the state, showed a large proportion of the population (54%) with an eighth grade education or less. According to the Spanish American Union's report, dropout rates from the Springfield High School system are high. It seems that current educational programs, particularly bilingual education, need revisions. As will be discussed shortly, the socioeconomic status of a family seems to play a special role on education.


Low levels of income and education typify the condition of most Puerto Ricans in the mainland, making them targets for poor health and the sequel of social problems
that are attached to poverty. That doesn't mean that there are no social classes among Puerto Ricans. There are intraethnic, intracultural variations within subgroups, and social class is a strong factor of differentiation causing stress and anxiety among individuals. Sonia Badillo Ghali (1977) has explained this stereotyping of classes—as follows.

Often when a poor Puerto Rican sees a professional worker, he is wondering what that person thinks of the poor, of the dark-skinned, of those inarticulate in the English language. Does the professional worker understand how the ghetto has affected him? What it is to be hungry, humiliated, powerless and broke? Does he really want to help or just do a job? The middle-class Puerto Rican will wonder if the professional person will attribute all of the usual stereotypes to him, or see him as an individual.

(p. 460)

The Spanish American Union's report on Puerto Ricans in Springfield also mentions the factor of social class in Puerto Rico and in the mainland. Referring to the population involved in the 1978 survey, it states:

There are Puerto Ricans living in the Springfield area outside the sampled tracts, some of whose socioeconomic status is what is commonly referred to as "middle class." Their number relative to the larger Puerto Rican community, is small. . .

(p. 12)

The report also discusses the emergence of a sizeable middle class in Puerto Rico, "with large numbers of persons employed in professional and managerial positions" (p. 19).
Health providers must be aware of class differentiations among individuals in order to avoid generalizations and stereotyping of patients in the name of "understanding the culture." After all, the importance of social class as a significant variable in health studies stems from its potentiality to predict health practices, beliefs and values—without forgetting individual characteristics.

Another issue to be discussed is "color," mentioned before in the Badillo Ghali quotation, because of its role in the lives of Puerto Ricans in the mainland.

Color. Color must be recognized by health providers and educators as a very important factor in the lives of Puerto Ricans in the mainland. It is one of the most common and painful problems encountered by many Puerto Ricans upon their arrival in the United States. In Puerto Rico, people are not identified in the dichotomy of black or white, but are rather described in a variety of "hues" suggesting lightness, darkness, and hair texture as follows:

Darker Puerto Ricans are "morenos," less dark Puerto Ricans are "trigueños," while still lighter Puerto Ricans may be described as "grifo" (light-skinned with kinky hair) or "indio" (having native Indian characteristics). All these terms imply some sort of racial mixture. However, the important consideration is that these intermediate tones . . . represent legitimate color variations.

(Longres, 1974: 70)
Suggestions have been made to identify Puerto Ricans as "Rainbow People," to emphasize pride in the Puerto Rican culture which has committed itself to minimizing color differences (O'Connor quoted by Longres, 1974).

Puerto Rican authors do not deny that there is a certain amount of "color awareness" in Puerto Rico, but claim that color is of little importance—particularly in the lower socioeconomic group. The primary source of self-identity is class. That is, many darker Puerto Ricans may be found in the elite class, and many white Puerto Ricans may also be found in the lower socioeconomic group. But upon their arrival to the United States, Puerto Rican families are immediately labeled "non-white," which means that they are suddenly classified with American blacks, consequently sharing stereotyping and prejudice (Sowell, 1981; Badillo, 1977). This racial discrimination practice in the United States has been described by Angela Jorge (1979) as follows:

> . . . American society constantly reaffirms through schooling, employment, housing, social interactions and institutions the inferior status of black people in this country.

(p. 135)

However, Jorge also accuses Puerto Ricans themselves of "covert racism, often overshadowed," in contrast to the United States, "an openly racist society."
Because children within the same family may show differences in color among each other—a result of the racial mixture among groups, dating back to the early history of Puerto Rico—some may be considered black and some white in mainland schools. This adds to the pains of acculturation of the family, sometimes with emotional and even destructive reactions among its members (Badillo, 1977; Mizio, 1974).

Julian Rivera explains this racial mixing in the island and the variety of hues among its people because of intermarriage during the Hispanic conquest. But he emphasizes the tolerance of color in Puerto Rico. He also comments on what criteria are used in the United States to define black people. Rivera (1974) says:

> Although Puerto Ricans come from various backgrounds, a great deal of racial mixing and intermarriage has taken place in the island owing probably to the island's isolation, to the shortage of European women in the earlier days of the colonization, and to other sociological factors. The result of that racial mixture is a general tolerance about color. However, in coming to live in the United States, Puerto Ricans have come in conflict with the American tradition that "one drop of black blood makes a blackman".

(p. 85)

Jorge calls that classifying practice the "descendant rule" which dictates "that a Negro is anyone having one drop of Negro blood." In Latin America, the opposite seems to be
true; "one drop of white blood," and people are not considered black. Actually, people are labeled "Hispanic," or "Puerto Rican," thus combining ethnicity and race. An example of this practice is the admissions form used in New York City—mentioned under factors affecting the health of Puerto Ricans in the mainland. The classification used was for "ethnic/racial group. Also, this classification did not specify whether the individual was black or white, but simply "Puerto Rican."

This problem with color in the United States is one of the reasons why darker Puerto Ricans may refuse to speak English—in order to preserve their identity and ethnic background. Therefore, color, as a preserver of self-identity and Spanish language as a symbol of ethnicity and pride, must be seriously considered in any interaction involving monolingual Puerto Ricans and their families in the mainland.

At this time, it is important to state once again that the factors described in this section are only guidelines that may help providers understand problems. Naturally, every individual is different and reacts accordingly. The factors presented are of importance in understanding the plight of Puerto Rican families in the mainland, especially their health problems and previous experiences. However, care must be exercised in order to avoid stereotyping individuals. Individualizing health care according to the
uniqueness of the patient/client and the family should be the guidelines for a successful patient-provider interaction.

A discussion of Puerto Rican families in the island and in the mainland follows in order to emphasize critical input of the family in health care.

Puerto Rican Families in the Island

We Puerto Ricans belong to a large family of people having a common identity, language, and heritage. We deserve to be considered on the basis of our unique story as a people whose culture is not less than the Anglo-American. We simply are, with no claims of superiority, nor any wish to be considered inferior, to any of the peoples living in the USA.

(Mercado, 1974: 150)

Traditionally the Puerto Rican family, as other Hispanic families, is patriarchal--regardless of class--with clearly defined roles among the sexes.

The father is the absolute ruler of the home. He has the final word and exercises firm authority over wife and children. He demands and receives "respeto" (respect) and obedience. He does not participate in the chores of the home or in the direct care of the children (Acosta-Belen and Sjostrom, 1979; Christensen, 1979), but he is considered the "macho," the protector and provider of the home (Fitz-
This macho role is expressed in relation to his family, his job, and the expectations of his fellowmen. When no male is available in a family, a male relative is called in, or the maternal grandmother undertakes the authority role because of respect for her age and position (Mizio, 1977; Hardy-Fanta and MacMahon-Herrera, 1981).

"Being a man," or "machismo" in Puerto Rico is described as follows:

In the culture of Puerto Rico being a man means having a keen sense of one's inner worth as an individual; receiving proper respect from people younger than oneself; manifesting fidelity to deep family loyalties and a preference of family over others; and demonstrating a mastery over those types of work which are a man's responsibility whether the humble cutting of sugar cane or the skills of a lawyer or architect.  

(Fitzpatrick, 1971)

Of course, "machismo" is not only typical of Puerto Rican males. The Latin American culture in general gives much emphasis to "machismo" in males and virginity in females (Christensen, 1979; Fitzpatrick, 1971). Females are expected to be virgins when they marry and to be docile and understanding (Mizio, 1977). The concept of Marianismo (the veneration of the Virgin Mary and of Motherhood) is extended to the Puerto Rican mother (Badillo, 1977; Canino and Canino, 1980.)

These cultural expectations are explained by Hidalgo and Hi-
Puerto Rican culture, like most cultures is dominated by sexist values. Machismo and virginity are strong values that continue to be entrenched in the culturally prescribed behavior. The machismo-virginity cult prescribes that the man be the sexual aggressor... Women are expected to reject sexual advances... to safeguard their virginity until marriage, to remain passive...

(p. 112)

Although male-female roles are in a state of transition all over the world, and even more so in the island of Puerto Rico (because of the Americanization process), it may be said that most of the described roles are still being observed now (Christensen, 1979).

The Puerto Rican woman, as most Hispanic women, is the center of the home, with the traditional role of homemaker, mother, and teacher of the "next" generation (Christensen, 1979). Her essentially domestic role as self-sacrificing mother (Acosta-Belen and Sjostrom, 1979; Hidalgo and Christensen, 1979) is perpetuated by rigid distinctions among the sexes, stereotyped and encouraged by the family and schools (Acosta-Belen and Sjostrom, 1979). Christensen, who married into a Puerto Rican family, says that females are permitted little aggressive behavior, which is considered a male attribute. He also mentions that the culture teaches females to detest either physical or emotional turmoil. Interestingly, the cultural roles that do not favor females are rein-
forced by the mother through her different expectations and socialization of female vs. male offspring (Christensen, 1979).

It seems that as the economy changes, roles change too in Puerto Rico. King (1979) explains:

As the economy of Puerto Rico becomes more industrialized a new social base is being created — the urban working class. With the emergence of this class, the role of the woman is being redefined. Increasingly, the authority and the culturally defined role of the wife as subordinate to the husband are giving way to the emancipation of the Puerto Rican woman, specially as she becomes more economically independent of man.

(p. 131)

Childrearing reflects the parental roles. Children are dearly loved and wanted, but from a very young age they are taught to be submissive, respectful of their elders and authority figures. In Puerto Rico, says Mintz:

In all classes obedience and "respeto" are most prized qualities in children . . . children under 10 should "fear," from 10 to 20 they should "respect," and over 20 they should "love" their parents.

(Mintz, 1973: 65)

Overt expressions of aggression by children are discouraged by Puerto Rican families, as opposed to the American values of aggressiveness (Badillo Ghali, 1977).
As in most Hispanic families, there is much respect for older people. The culture does not conceive of nursing homes, except on very rare occasions. The extended family takes care of parents, and grandparents. The culture frowns on the institutionalization of elders, as was previously explained under the Hispanic Family.

The same is true for baby-sitters. Very few families rely on the services of strangers for child care. That is the function of the extended family, which includes grandparents, aunts, uncles, cousins, nephews, nieces, and "compadres" or "comadres"—co-parents (ritual kinship). This is a Hispanic custom that was explained in more detail in Chapter III. Particularly in small towns in Puerto Rico, everyone is concerned with children besides the extended family—even storekeepers and teachers, besides neighbors and friends (Badillo, 1977).

Unfortunately, because of unemployment and a search for better opportunities, the family must leave the island. Painful acculturation ensues.

Puerto Rican Families in the Mainland

Puerto Ricans are best described as an uprooted people... they have found a hostile society that discriminates against them because of their color, language and culture... The lack of opportunities and their own lack of skills have forced Puerto Ricans to live in a deplorable state of misery. They hold the least desirable jobs and
and have the lowest income, the highest percentage of public assistance . . . they are forced to live in the most dilapidated houses in the worst neighborhoods . . .

(Rivera, 1974: 87)

Forced by unemployment and poor economic conditions in the island, Puerto Ricans leave for the mainland with hopes for better working opportunities and lifestyles. But upon arriving in the United States these poor, semi-rural, usually monolingual, young, and unskilled families find themselves in a hostile environment, sharing many characteristics of other low-income working classes, but their plight is compounded by the effects of migration, acculturation, lack of knowledge of the English language, distance from their extended families, and discrimination (Canino and Canino, 1980).

In contrast to his position in Puerto Rico, the head of family loses his self-respect and dignity because of unemployment, added to language and educational problems. Besides a lack of proficiency in English, he is not prepared or trained to work in a technological society (King, 1979). Being unable to get a job results in role reversals. His role as a provider and protector disappears. He finds himself depending on his wife or partner to support him and the family. The specter of welfare haunts the family. This plight of poor Puerto Ricans in the mainland, "newcomers of the aviation age," and American citizens—not foreigners, like individuals of previous immigration waves—is expressed by Fitzpatrick (1971) as:
They come when automation is creating a new kind of economy, and jobs which once were the great channels of immigrant advancement are being eliminated by the hundreds of thousands . . . They come when the City and Federal Governments provide a range of public services from public housing to welfare, which did not exist half a century ago.

(p. 3)

Although those words were written almost fifteen years ago, the situation still persists and the comments are still valid. Unemployment in the island is double that of the mainland. Also, health, wages, and welfare benefits are better in the United States than in Puerto Rico (Amaral, 1980).

The shift in family roles causes stress and anxiety among the members of the newly arrived Puerto Rican family, eroding family life and adding to instability. Mental disorders, drinking, and other deviant behavior ensues (as explained previously under "Factors Affecting the Lifestyle and Health of Puerto Ricans in the Mainland).

The stress, struggle, and role reversals in the family have also an influence on children. The older boys, specially, become distant and hostile. Because of their new ability to speak English, they can get jobs that their fathers cannot perform. The "parentified child," with interpreter/translator responsibilities may then turn defiant, disrespectful,
independent, and non-submissive—traits alien to the culture. Parents react with excessive restrictions and strict home regulations that trigger more defiant behavior among Puerto Rican children in the mainland (Canino and Canino, 1980). Although not referring to this situation as the problem of the "parentified child," but as the result of acculturation and language proficiency, Mills (1967) says:

Difficulties often arise when children learn English and find that they hold a whip hand over the parents who speak only Spanish, or speak English brokenly... They become an insecure second generation—estranged from the parents and their culture and from neighbors and theirs. They become the culturally homeless, to whom not social but institutional controls are applicable.

(p. 98)

As a symbol of their control over the children, parents then demand that Spanish be spoken in the home. Grandparents, residing in the same household, express their desire to be greeted and addressed in the Spanish language. Thus, Spanish acquires an added dimension—controlling the young of the Puerto Rican families in the mainland, and preserving traditions associated with the extended family and the Motherland, Puerto Rico.

Sometimes Anglo professionals from child care and welfare agencies in the United States misinterpret the Puerto Rican concept of discipline and may confuse it with child
abuse. Parental authority is then undermined by the well-meaning Anglo professionals who fear "disciplinary incompetence," creating a confrontation between parents and their children (Canino and Canino, 1980; personal conversations with Springfield health care professionals, 1982-84).

Incidents occur when Puerto Rican children become too disrespectful, in the opinion of the family, while actually following the behavior patterns expected of their peers in Anglo schools. The family may react by sending the child back to Puerto Rico to the extended family for correction (Badillo Ghali, 1977). Thus, Puerto Rican children that arrive in the mainland are frequently caught between two subcultures: that of school—with the influence of peer groups in urban areas of the United States—and that of the family, with its strict rules and defined roles. Teenagers caught in this conflict of cultural values and family expectations frequently become confused, reject themselves, become defensive about their background, and sense that they must apologize for the low esteem in which the group is held (Badillo, 1977).

Considering that at the present time there are more than two million Puerto Ricans dispersed throughout the country—including New York City, New Jersey, Pennsylvania, Wisconsin, Massachusetts, Ohio, Indiana, Illinois, Florida, Connecticut, and as far West as California and Hawaii (King, 1979)—it is imperative that providers be informed of these
cultural problems among Puerto Rican families. The role of the provider should be that of a "bridge," supporting the parents' authority, avoiding antagonizing encounters, and becoming culturally sensitized to the needs of the family. Underutilization of services may occur when parents do feel threatened by the school or agencies.

Furthermore, professionals should discourage the "parentified child" to act as interpreter/translator for the health conditions of the parents, particularly the mother. It is very embarrassing for Puerto Rican women to trade messages dealing with bodily functions—specially gynecological problems—with their health providers via their children's translations. It is time for providers and health agencies to realize that it is not only a matter of translation, but that cultural and familial traditions are actually transgressed. Recognizing that interpreters should be trained experts in order to fulfill such a critical role, Mizio (1977) says:

On too many occasions Puerto Rican clients have to bring in children as interpreters which undermines the family structure by placing the child in a position of authority and involving him or her in adult affairs.

(p. 472)

Also, health providers must understand the interdependence among members of the Hispanic family in general and Puerto Ricans in particular. There is no stigma attached to fam-
ily dependency. In seeking help, many Puerto Ricans in the mainland first approach family members, "compadres" (members of the extended family by ritual kinship, mentioned in Chapter III), friends, and neighbors. Then teachers, clergymen, and other educated people in the network will be consulted. Only as a last resort will agencies or institutions be approached. Hardy-Fanta and MacMahon-Herrera (1981) explain this process as follows:

Hispanic families are very invested in family life; interaction within the family group and a system of mutual rights and obligations lead not to the Anglo pattern of independence from family, but rather to continued interdependence between family members that is maintained throughout adulthood. . . Treatment of individual members would only lead to increased fragmentation of services. . .

(p. 140)

Therefore, if the patient is expected to comply, the family must be included in the treatment. Otherwise, some studies indicate that approximately 65% of the patients/clients drop out of treatment (Badillo, 1977.)

In considering the different factors that affect the health of Puerto Rican families in the mainland, it is important to remember that the environment plays a very crucial role. Above all, local needs must take priority over health models or literature not directly connected with the target community. Therefore, while the Health Findings (Alers, 1978) may be considered an excellent model—since over 50% of Puerto
Ricans in the mainland reside in New York City—it does not mean that local communities in other areas are also experiencing the same problems. Similar conditions may exist, but there are other local factors that must be considered first. As Elena Padilla (1958) has stated, the environment influences the culture and lifestyles of individuals—even those of the same ethnic group. Padilla says:

The culture of Puerto Ricans in New York cannot be characterized as "Puerto Rican," for it is not the same as that of Puerto Ricans in Puerto Rico. Rather the culture of Puerto Ricans in New York has developed in accordance with the circumstances of their lives in this city.

(p. 31)

These "circumstances" may include factors like degree of acculturation, language proficiency, size of the community—with its potential to exert political power because of large concentrations of individuals of the same ethnic group and socioeconomic status. Numbers count. (Excuse the pun).

By not considering these factors—among others—many health studies and programs are not valid and are methodologically tainted. There is a need for valid, reliable, and carefully planned health studies on the health needs of local Puerto Rican populations. That will be considered in Chapter V, the applied part of this dissertation—the Descriptive Study—which follows the next discussion, an anthropological approach to the health problems of Puerto Rican families.
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Vilma Rivera and Maggie Torres for helping me type this dissertation.

The patients of Wesson Women's Hospital at Baystate Medical Center, without whose participation the applied part of this dissertation could not have been attempted.
Anthropologists have long realized that illness beliefs and their associated practices are intimately woven into the pattern of a specific sociocultural existence... socioeconomic impediments to health care... exacerbated by sociocultural factors.

(Harwood, 1980: 299, 314)

The contribution of anthropology to the understanding of health problems of individuals and families—in context—is invaluable. Alan Harwood exemplifies the commitment of medical anthropology to health maintenance and disease prevention by stressing a relationship between a patient's health beliefs, values and practices and his/her ethnicities. This anthropological approach emphasizes the dangers of stereotyping people and cataloguing or labeling individuals like specimens rather than persons.

Harwood states that ethnically influenced concepts of disease and illness do in fact affect other health behaviors, such as perception of symptoms, evaluation of severity of disease, treatment, medications to be taken, whether to comply or not with providers' advice, or whether to seek treatment somewhere else.

Furthermore, Harwood recommends the inclusion of both factors, ethnicity and social class, in order to understand the health problems of behavioral ethnics, discussed on pp. 100 and 101.
Gretel and Pertti Pelto (1979) educators and active researchers in Medical Anthropology at the University of Connecticut in Storrs, also agree with Harwood about first and second generation behavioral ethnics and difficult socioeconomic conditions. They further state that health problems reflect socioeconomic status, but that even within those poverty-stricken communities there are differences. The Peltos state:

. . . there are very great differences in the ways that the overall social and economic system—the surrounding social environment—affects individuals. All of these kinds of differences are intracultural variations, and focusing on these intracommunity variations and their patterning helps to make sense of how people manage to cope with economic marginality in a highly stratified and unequal social system.

(p. 227)

While writing on the influence of class, ethnicity, and the environment that impact on the stress experienced by Puerto Rican families in the mainland, Canino and Canino (1980) also acknowledge the need for an anthropological framework. They state that it is not enough to undertake a study of a group based only on its ethnic component. They emphasize the importance of considering both factors—social class and ethnicity—in order to understand family problems caused by migration, poverty, urbanity/rurality, and the influence of the environment. These investigators focus on
low-income Puerto Ricans as a subculture—sharing many of the characteristics of poor people. Canino and Canino suggest an "ecostructural family approach" to therapy that assumes "a person is influenced by his context, that is, his sociocultural, familial, political, and economic environment."

Blanca Fernandez-Pol (1980) in her study of poor Puerto Ricans in New York and their problems with culture and psychopathology, explains that "Puerto Ricans may be experiencing conflicts as a result of progressive Americanization, with its accelerated change in value systems." She states that the shock of acculturation creates new roles and new perceptions, forcing changes to cope with new surroundings. The environment then influences deviant responses, and the result is a sequel of mental problems among member of Puerto Rican families.

In connection with the interaction of ethnicity, social class, and the environment, two ethnic diseases will be discussed. These are "ataque," also known as the "Puerto Rican Syndrome," and asthma.

"Ataque" is described by Badillo Ghali (1977) as a form of hysteria, characterized by nonepileptic seizures—although they may look similar because they are hyperkinetic—a response to acute tensions and anxiety. It seems that "ataques" are culturally expected reactions to unpleasant or stressful situations; they usually follow family conflicts, deaths, or arguments.
Harwood (1980) describes "ataque" as follows:

... it is most commonly used to refer to a sudden partial loss of consciousness, accompanied by either clonic or tonic seizures and at times by screaming, tearing of clothing, or foaming at the mouth. Such attacks may last from a few minutes to as many as four days ... and terminate as suddenly as they began. This form has entered the medical literature as "the Puerto Rican Syndrome" ... (pp. 418-419)

In citing Garrison (1977), Harwood says that the attacks are also expected "from some women when they do not get their own way or when they are faced with an act of aggression they cannot otherwise stop." But Harwood explains that there are different types of "ataques" among Puerto Ricans. This is very important and significant for health care providers. There is another type of "ataque" that is linked to spiritual disturbances. Psychiatric treatment is, therefore, hindered because that type of illness is supposed to be understood only by "culturally acceptable spiritual healers." Therefore, treatment becomes part of a psychiatric intervention instead of a cultural disturbance. As Harwood explains it, when the patient is examined or interviewed by health care professionals, he is labeled "loco," while the cultural label would be "nervous (nervioso) or "enfermo de los nervios" ("nerve-sick"). Harwood warns providers that both the patient and the family must be probed to ascertain what they
believe is the source of the "ataque. If providers can as-
certain that the interpretation of the "ataque" is culturally
determined, then the intervention of the family and open com-
munication techniques will help. If it is believed that the
attack is spiritually caused, then it is better to use "spirit-
ism interventions, mentioned before in Chapter III.

The other ethnic condition among Puerto Ricans is asthma.
Guarnaccia (1981), a medical anthropologist, has done exten-
sive work in asthma among Puerto Ricans in Hartford. He cites
a number of ecological, sociocultural, and psychosocial fac-
tors that may be responsible for the prevalence of asthma
among the Puerto Rican population in Hartford, Connecticut.
Guarnaccia differentiates between two types of asthma accord-
ing to etiology: extrinsic or hypersensitivity response to
allergens, and intrinsic—triggered by emotions and lung in-
fections. Intrinsic asthma seems to be closely linked to the
problems of unemployment and family stress; a result of the
stress of migration on family dynamics. Furthermore, Guarnaccia
mentions that molds, high humidity, and problems associated
with poverty—poor ventilation, insects, and even parasites
may be responsible for asthma attacks. Cockroaches, leaving
a film on foods they infest seem to be a cause, precipitating
allergy reactions. But Guarnaccia also mentions the diffi-
culty in differentiating this disorder from other respiratory
ailments.
Harwood also agrees that what some Puerto Ricans may call "asthma" may be another milder respiratory ailment, "fatiga," which he describes as:

The acute conditions labeled "fatiga" or "asma" . . . were either acute respiratory infections (accompanied by shortness of breath and fever and termed "fatiga" by the sufferers or their caretakers) or isolated instances of shortness of breath or wheezing which had never been clinically diagnosed as asthma.

(Fn. 10: 469, 1980)

Harwood mentions stress as a culprit in the occurrence of asthma, particularly among young and middle-aged women. He says that it almost seems like a cultural cue for women who are particularly upset or "trapped" in difficult situations to have an asthma attack.

Both Guarnaccia and Harwood encourage further anthropological studies and investigations among Hispanics. They suggest poor housing facilities, nutritional deficiencies, and fear of cold weather may worsen conditions and influence disease causation. Care must be taken by providers, therefore, when Puerto Rican patients are brought into the emergency rooms in the mainland. Interpreters must be warned of the vocabulary or terms used by the patients or their families to explain asthma. If it is a milder respiratory condition, it might be enough to reassure the patient not to be anxious since it is probably only "fatiga." The patient should then be taught some simple tech-
niques to be able to relax and breathe more comfortably, with the cooperation of the family. In describing asthma as a "reversible" obstructive airway illness, Guarnaccia has stressed the role of patient education and the patient-provider interaction in the success of asthma treatment. Although this psychosocial disease is not curable, it may be controlled and remain in remission for long periods.

Another invaluable resource in the discussion of ethnicity and health care is the work of Hogle, Pelto and Schensul (1982). These medical anthropologists from the University of Connecticut at Storrs have been studying the relationship between ethnicity and health behavior from an anthropological as well as from a practical, applied approach. Their study of low-income Puerto Ricans in the Charter Oak Terrace/Rice Heights Health Center in Hartford, Connecticut, states that "people of lower socioeconomic status tend to display behavioral ethnicity in health matters to a greater extent than those of higher socioeconomic standing." However, these researchers say that the data gathered on these behavioral ethnics and "traditional" or folk beliefs and practices is rather limited. For example, in speaking about the use of spiritism locally, Hogle et al claim that the encounters are "statistically rather infrequent." Therefore, in the opinion of these anthropologists, knowledge of "espiritismo," would not contribute very much to a doctor's awareness of patients' needs. However, knowledge of folk practices should not be ignored.
A factor that must be considered in dealing with basically unsophisticated families of rural backgrounds—who may easily turn to alternative sources of care, such as traditional medicine, is to ask about the use of herbs, potions, and remedies that may be used with other prescribed medications. As the health care provider interviews the patient, health beliefs and practices may become identifiable. Negative synergistic effects of medicines may be avoided and possible adjustments or changes in treatment may be effected.

Health care providers must be aware that a store common to many Puerto Rican communities in the mainland is the "botanica," or specialty shop. Herbs, potions, idols, incense, rosaries, and remedies are sold in a coalition of Indian, African, and Spanish medications, amulets, and other articles. The problem is that some of the plants are toxic and may harm the users. It has been suggested that "botanicas" be used as places where patients may get health information, properly administered by public health agencies who have been sensitized to the local needs of the community. That may not be a bad idea, provided that there is a demand for "botanicas" in a particular community. Certainly, this is a suggestion that merits more investigation.

Anglo health care providers must be fully aware of the implications of ethnic diseases and medications among their Puerto Rican patients. By adopting an anthropological framework, it may be possible to assess patient needs, alleviating
pain, increasing trust, and improving the patient-provider interaction. It is very important that health providers be aware of the multicomplex factors affecting the health of Puerto Rican families in the mainland, particularly ethnic conditions affecting the poor. Suggestions have been made (Harwood, 1980; Kiev, 1982; Kleinman, 1981; Saunders, 1954) that cosmopolitan health providers adopt the personalistic approach of folk practitioners, with their dependence on body-mind-spirit-social network-technique, to deal with the health care of individuals. Clearly, those suggestions agree with the objectives of this work: educating the providers to the factors affecting the lives of Puerto Rican families in the mainland. Compliance then may be fostered and quality care may be reinforced.

The "Descriptive Study" follows, an applied part of the dissertation designed to investigate the schedule-keeping behavior of 50 women patients at a local hospital. The Study will be followed by the Conclusions, with some recommendations and suggested strategies to improve the health care of Puerto Rican patients in the mainland in particular and Hispanic patients in general.
A DESCRIPTIVE STUDY OF COMPLIANCE AMONG PREGNANT PUERTO RICAN WOMEN AT BAYSTATE MEDICAL CENTER IN SPRINGFIELD, MASSACHUSETTS

Introduction

Women from certain minority groups are half as likely as white women to receive the minimum of prenatal care recommended by the American College of Obstetrics and Gynecology... (In 1978, 40% of black mothers and 45 percent of American Indian mothers received no prenatal care during the first trimester; percent of Hispanics is unknown.)

(Excerpts from Health United States 1980: 24, 308 - Underlining mine)

Because of the vulnerability of most women during the stages of pregnancy, one of the five national goals for health promotion and disease prevention for the coming decade in the United States is to improve infant and maternal child care. Among minority women the risks of poor birth outcome are doubled and maybe even tripled. Patient and provider health education are major goals in the prevention of problems during pregnancy, specially among poor Hispanic women.

During my long association with Wesson's Women Unit (more than fifteen years), the above goals have been my objectives. At the invitation of Baystate Medical Center, this study was conducted at Wesson's Women Unit of BSMC in order to
investigate variables influencing patient compliance with prenatal and diagnostic test appointments among a sample of fifty Puerto Rican women in Springfield, Massachusetts.

Compliance or Patient Compliance may be briefly defined as "following the health care provider's instructions or recommendations." The opposite of compliance is "non-compliance," which has been referred as "sabotage to treatment." Contrary to assumptions and flawed reports (including a recent study by Morse, Coulter, Hwange, and Lawrence, 1984), non-compliance is a quasi-universal issue (Hayes-Bautista, 1976) and cannot be explained as a characteristic of any particular personality, type or group (Becker, 1976; Gunter-Hunt, 1982; Rotter, 1977).

This paper will focus on appointment-keeping non-compliance, a problem that plagues many health care agencies. By focusing the investigation on factors affecting compliance in a local health setting, program changes may be accomplished. By increasing the health care provider's understanding of non-complying behavior, Anglo health care providers may be sensitized to the plight of Puerto Rican patients.

It is hoped that this practical part of the doctoral dissertation which is entitled, "Intraethnic, Intra-cultural Variations and Similarities Among 'Hispanics' in the USA: Implications for Patient Compliance and Provider Health Education" will help in understanding some of the factors involved in local non-compliance. Hopefully, changes in the
methods of health care delivery may occur which will make it
easier for pregnant Puerto Rican women to keep appointments.

Assumptions

1) More than one half of the Hispanic patients not
keeping their appointments at Wesson Women's clinic will
have no phone. Therefore, they may not be able to be con-
tacted as possible participants in the non-compliance
project.

2) At least one fourth of the non-compliant women
will not be able to participate because they will have
moved away from the area and their telephones will have
been disconnected.

3) At least one half of the sample will be below
twenty-five years of age.

4) At least one half of the sample will have entered
the system in the last trimester of gestation.

5) At least one half of the sample will be single
parent/head of households.

6) Most of the women participating in the project will
have no outstanding hospital debts or unpaid bills because
they are on Medicaid.
7) Most of the women will be housewives, not working mothers, and will have more than four children living with them at home.

8) At least one fourth of the women will not be able to read either in English or in Spanish.

9) More than half of the sample will be monolingual, Spanish-speaking women with problems of communication.

10) Three fourths of the sample will have attained an 8th grade education.

11) More than half of the sample will have an awareness of the hot and cold theory.

12) More than half of the sample will be dissatisfied with health care services received during pregnancy at Wesson Women’s.

Methodology

Because of the process of dissertation proposal review, this investigation did not start until September 10, 1984.

A bilingual English/Spanish Questionnaire (Appendix A) was developed by the principal researcher and the Clinical Director of the project following demographic, structural and personal characteristic variables mentioned in the Proposal to Baystate Medical Center (Appendix B), approved by Baystate’s Committee on Medical Education and Research and the Committee on Use of Human Subjects in Research, Protocol No. BMC84-7-1 (Appendix C).
Demographic information available in Baystate Medical Center records was utilized. Participants were selected, based on Spanish surnames, from daily appointment lists. As has been discussed in another part of this dissertation, the method of including participants in studies on the basis of Spanish/Hispanic surnames has a potential for excluding Hispanics with non-Spanish names, such as the principal investigator's and including Anglos with Hispanic names. Only one potential incident of inclusion occurred. As to exclusions of Hispanics with non-Spanish names, provisions were not made for such occurrences in this study.

A weekly list was presented to the principal investigator indicating the names, phone numbers, dates, and nature of the missed scheduled appointments. Alternate telephone numbers—usually that of a relative or neighbor—were also supplied. Interviews were conducted in English or in Spanish, depending on the preference of the participants. All women contacted agreed to participate in the project.

Participants were interviewed by phone between 7:30 p.m. and 9:30 p.m. on weekdays and between 10:00 a.m. and 9:00 p.m. on weekends. The patients were reassured of their anonymity throughout the project and informed that a Consent Form (Appendix D) would be attached to their Medical Record. (It was presented for patients' signature during their next scheduled appointment.) Numbers were assigned to completed questionnaires
and only the Clinical Director of the Project, and this researcher had access to matching identification cards.

According to records kept at the clinic between the dates of September 4, 1984 and November 23, 1984, the total number of appointments booked in Hispanic names was 758 (39.6% of the caseload). Of these, 143 appointments (18.9%) were not kept by Hispanic patients. The Clinical Director gathered data on 120 potential participants. These 120 potentials constituted 71 cases distributed as follows:

<table>
<thead>
<tr>
<th>Cases</th>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>39 women missed 1 appt. only</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>32 women missed 2 or more appts.</td>
<td>81</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>120</td>
</tr>
</tbody>
</table>

Of the 71 cases, 34 (49.3%) had no phone and listed no contact phone in their records, 3 moved away from the area, 1 transferred to another provider, and 2 were clerical errors (came in late, but were examined). Therefore, 40 cases out of 71 were eliminated from the study. By the third week in November 1984, 12 patients had participated and 19 were being followed up by the investigator. Since at least 30% of those phones were disconnected and 10% were either wrong numbers (clerical as well as patient errors) or the women were away, an average of two telephone interviews were completed weekly. In order to reach the patients who were not available during calling hours, a brief letter (Appendix E) was, therefore, sent to 13 women at the end of November. The short bilingual letter, informally, explained the purpose of the project and requested the women to participate in the interview. A phone
number where the potential participants could reach the principal investigator was given. Only 3 patients responded to that written message.

Due to changes in staffing patterns at Wesson Women's it was decided in early December that the sample should be limited to 35 women, instead of the original 50. It was also decided that the survey would be ended at the end of December 1984 or at the most in the middle of January 1985. With the help of the Clinic Supervisor, the data collection was completed on January 15, 1985.

Results of the 35 interviews follow. However, before starting the Data Analysis it is important to include in the Methodology the operational definition for "health care provider." This study defines that term as "every professional and paraprofessional involved in patient care." That definition includes clerical staff and volunteers.
Data Analysis and Results

Data gathered from interviews of 35 respondents was processed by using an SAS statistical package. Frequency tables for each variable are shown separately. Vertical bar charts for some significant variables are also included. Each variable affecting compliance will be discussed separately.

In this data analysis, variables do not follow the exact sequence of the Questionnaire (Appendix A). However, they do follow the demographic, structural, and personal characteristics listed in the Proposal (Appendix B).

Due to the nature of this applied part of the dissertation, a descriptive study, and limitations because of the size of the sample—35 participants—major statistical tests or hypothesis testing procedures cannot be included in the analysis. However, future studies involving larger samples may endorse the significance of the variables selected for local studies.

Language Preference for Interview. As Table 1, Chart 1, indicate, 57% of the sample preferred to conduct the telephone interview in Spanish, 20% chose English, and 23% said they could be interviewed in either language, indicating a bilingual capability.

<table>
<thead>
<tr>
<th>LANGUAGE PREFERRED FOR INTERVIEW</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENGLISH</td>
<td>7</td>
<td>7</td>
<td>20.000</td>
<td>20.000</td>
</tr>
<tr>
<td>SPANISH</td>
<td>20</td>
<td>27</td>
<td>57.143</td>
<td>77.143</td>
</tr>
<tr>
<td>EITHER ONE</td>
<td>8</td>
<td>35</td>
<td>22.857</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 1
PERCENTAGE BAR CHART

PERCENTAGE

50

40

30

20

10

ENGLISH  SPANISH  EITHER ONE

V1  LANGUAGE PREFERRED FOR INTERVIEW

Chart 1
SAS
PERCENTAGE BAR CHART

PERCENTAGE

70

60

50

40

30

20

10

UNITED STATES

PUERTO RICO

V2 BIRTH PLACE

Chart 2
Demographic Variables

Birthplace:

For purposes of this study, only women born in Puerto Rico or those born in continental United States of Puerto Rican heritage were considered. 71.4% were born in Puerto Rico, while 23.6% were born in the USA. (Chart 2, Table 2).

<table>
<thead>
<tr>
<th>BIRTH PLACE</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNITED STATES</td>
<td>10</td>
<td>10</td>
<td>28.571</td>
<td>28.571</td>
</tr>
<tr>
<td>PUERTO RICO</td>
<td>25</td>
<td>35</td>
<td>71.429</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 2

Self-Identification of Hispanic Heritage:

Although 10 respondents (28.6% above), were born in continental USA, only 3 (8.6%) considered themselves "American," another 2.9% declared themselves "both," and the majority, 31 women (68.6%) said they were "just Puerto Rican," a significant factor extensively discussed in the theoretical part of this work. Puerto Ricans are American citizens, but there is an intense pride and nationalistic feeling in being simply "PR." (Table 3, Chart 3)

<table>
<thead>
<tr>
<th>SELF-IDENTIFICATION</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>PUERTO RICAN</td>
<td>31</td>
<td>31</td>
<td>88.571</td>
<td>88.571</td>
</tr>
<tr>
<td>AMERICAN</td>
<td>3</td>
<td>34</td>
<td>8.571</td>
<td>97.143</td>
</tr>
<tr>
<td>BOTH</td>
<td>1</td>
<td>35</td>
<td>2.857</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 3
PERCENTAGE BAR CHART

PERCENTAGE

100
80
70
60
50
40
30
20
10

V3 SELF-IDENTIFICATION
Chart 3
Age:

As mentioned in the review of literature on Hispanics and the Puerto Rican subgroup, the reproductive age of these women is rather young. In this sample, no one was over 38 years of age; 11.4% were older than 30; 5.7% were between 26 and 30 years old; 17.1% were between 15 and 19, and 2.9% of the sample were 14 years old. The majority of the women, 62.9% were between the ages of 20 and 25.

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Frequency</th>
<th>Cum Freq</th>
<th>Percent</th>
<th>Cum Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 15</td>
<td>1</td>
<td>1</td>
<td>2.857</td>
<td>2.857</td>
</tr>
<tr>
<td>15 to 19</td>
<td>6</td>
<td>7</td>
<td>17.143</td>
<td>20.000</td>
</tr>
<tr>
<td>20 to 25</td>
<td>22</td>
<td>29</td>
<td>62.857</td>
<td>82.857</td>
</tr>
<tr>
<td>26 to 30</td>
<td>2</td>
<td>31</td>
<td>5.714</td>
<td>88.571</td>
</tr>
<tr>
<td>More than 30</td>
<td>4</td>
<td>35</td>
<td>11.429</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 4

5. Marital Status:

Close to half of the sample (49%) were single, 28.6% married, 20% separated and less than 3% were divorced. If single, separated, and divorced were considered as a block, the percentage of single parent families becomes 79% of the sample, with serious implications that will be discussed later. (Table 5, Chart 5)

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Frequency</th>
<th>Cum Freq</th>
<th>Percent</th>
<th>Cum Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>17</td>
<td>17</td>
<td>48.571</td>
<td>48.571</td>
</tr>
<tr>
<td>Married</td>
<td>10</td>
<td>27</td>
<td>28.571</td>
<td>77.143</td>
</tr>
<tr>
<td>Separated</td>
<td>7</td>
<td>34</td>
<td>20.000</td>
<td>97.143</td>
</tr>
<tr>
<td>Divorced</td>
<td>1</td>
<td>35</td>
<td>2.857</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 5
PERCENTAGE BAR CHART

AGE

Chart 4
PERCENTAGE BAR CHART

<table>
<thead>
<tr>
<th>PERCENTAGE</th>
<th>SINGLE</th>
<th>MARRIED</th>
<th>SEPARATE</th>
<th>DIVORCED</th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Chart 5
Trimester of Entry:

At WHH, a trimester of entry is defined as the gestational period in which pregnant women initially attend the clinic. The first trimester is considered between the 1st and 12th weeks of pregnancy; the second trimester from the 13th to the 28th, and the third trimester is over 28 weeks. In this study, almost a half of the sample (49%) entered in the first trimester, 37% in the second, and 14% in the third. Since the first trimester of pregnancy is a critical stage in which women must be seen by health care providers, and since more than half of the sample did not seek health care until their second and third trimesters, more outreach and health education programs may be necessary. (Table 6, Chart 6)

<table>
<thead>
<tr>
<th>Trimester of Entry</th>
<th>Frequency</th>
<th>Cum Freq</th>
<th>Percent</th>
<th>Cum Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIRST TRIMESTER</td>
<td>17</td>
<td>17</td>
<td>48.571</td>
<td>48.571</td>
</tr>
<tr>
<td>SECOND TRIMESTER</td>
<td>13</td>
<td>30</td>
<td>37.143</td>
<td>85.714</td>
</tr>
<tr>
<td>THIRD TRIMESTER</td>
<td>5</td>
<td>35</td>
<td>14.286</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 6

Length of Residence in Springfield:

Three of the women (6.6%) in the sample were not residents of Springfield. (Two were from Holyoke and one from Chicopee.) More than 50% of the residents had lived in the city six years or less, usually between 0 and 3 years. The mobility of urban Puerto Ricans, which is discussed in the literature review of this work as one of the barriers in health, may be supported by these findings. Table 7 and Chart 7 illustrate these frequencies.
PERCENTAGE BAR CHART

<table>
<thead>
<tr>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>40</td>
</tr>
<tr>
<td>30</td>
</tr>
<tr>
<td>20</td>
</tr>
<tr>
<td>10</td>
</tr>
</tbody>
</table>

FIRST TRIMESTER: 40%
SECOND TRIMESTER: 30%
THIRD TRIMESTER: 20%

Chart 6
Place of Education: As shown on Table 8, more than one third of the sample attended school only in Puerto Rico. In addition to this, if those attending school in both Puerto Rico and USA were added to the category "Puerto Rico," then more than half of the sample had some schooling on the island. In contrast, only 29% were educated in Springfield.

Table 8
Years of study. The data shows that 57% completed up to 12 years of schooling, 40% dropped out of school in the 9th grade, and 13% completed the 8th grade. It is of interest to notice that the majority dropped out of school in the 9th grade.

<table>
<thead>
<tr>
<th>YEARS OF EDUCATION</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>LESS THAN 5TH GR</td>
<td>3</td>
<td>3</td>
<td>8.571</td>
<td>8.571</td>
</tr>
<tr>
<td>5TH TO 8TH GRADE</td>
<td>5</td>
<td>8</td>
<td>14.286</td>
<td>22.857</td>
</tr>
<tr>
<td>9TH GRADE</td>
<td>14</td>
<td>22</td>
<td>40.000</td>
<td>62.857</td>
</tr>
<tr>
<td>10TH TO 12TH GRADE</td>
<td>13</td>
<td>35</td>
<td>37.143</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 9

Present Occupation. Eighty of the sample declared themselves as housewives, 9% as students, and 11% had a job. Most women stated that they were satisfied being home rather than in the workforce or in school. (Table 10)

<table>
<thead>
<tr>
<th>FREQUENCY</th>
<th>OCCUPATION</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>28</td>
<td>HOUSEWIFE</td>
<td>80.000</td>
<td>80.000</td>
</tr>
<tr>
<td>4</td>
<td>JOB</td>
<td>11.429</td>
<td>91.429</td>
</tr>
<tr>
<td>3</td>
<td>STUDENT</td>
<td>8.571</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 10
PERCENTAGE BAR CHART

YEARS OF EDUCATION

Chart 8
Structural Variables

Accessibility of Clinic

Three questions were asked to explore this issue.

**Distance to the Clinic:** 49% said the clinic was too far, 34.2% said it was not too far, and 17.1% stated that the distance was in-between. However, these declarations contrast with the next two variables. (Table 11, Chart 9)

**Type of Transportation Used:** 49.5% said that they walked to the clinic, 28.5% took the bus, 17.1% went by car, and 6% took a taxi. (Table 12, Chart 10)

<table>
<thead>
<tr>
<th>TYPE OF TRANSPORTATION USED</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>WALKING</td>
<td>17</td>
<td>17</td>
<td>48.571</td>
<td>48.571</td>
</tr>
<tr>
<td>BUS</td>
<td>10</td>
<td>27</td>
<td>28.571</td>
<td>77.143</td>
</tr>
<tr>
<td>PRIVATE CAR</td>
<td>6</td>
<td>33</td>
<td>17.143</td>
<td>94.286</td>
</tr>
<tr>
<td>TAXI</td>
<td>2</td>
<td>35</td>
<td>5.714</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 12

**Difficulty in Getting to the Clinic:**

Almost half of the respondents, 49% said it was not too difficult to get to the clinic, 43% said it was difficult, and 8.5% said that sometimes it was difficult. (Table 13, Chart 11)
### Table 11

<table>
<thead>
<tr>
<th>Distance to Clinic</th>
<th>Frequency</th>
<th>Cum Freq</th>
<th>Percent</th>
<th>Cum Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not too far</td>
<td>12</td>
<td>12</td>
<td>34.286</td>
<td>34.286</td>
</tr>
<tr>
<td>Far</td>
<td>17</td>
<td>29</td>
<td>48.571</td>
<td>82.857</td>
</tr>
<tr>
<td>In between</td>
<td>6</td>
<td>35</td>
<td>17.143</td>
<td>100.000</td>
</tr>
</tbody>
</table>

#### Percentage Bar Chart

<table>
<thead>
<tr>
<th>Percentage</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

---

**Distance to Clinic Chart**

**Chart 9**
PERCENTAGE BAR CHART

TYPE OF TRANSPORTATION USED

Chart 10
DIFFICULTY IN GETTING THE CLINIC

Chart 11
Clinic Environment

Several questions in the bilingual questionnaire dealt with this variable. Women were told that their frank responses concerning their impressions of the clinic would be helpful in improving health care for them and other patients like them.

Satisfaction with the Clinic

Two respondents were not satisfied with care at WWH. Most women said the help and personnel were "very nice". 51.4% were very satisfied, 29% were satisfied, 14% said they were somewhat satisfied, the rest (6%) were not satisfied. (Table 14, Chart 12)

Suggestions for Improvement of Present Services

the responses to questions concerning possible improvements were quite positive, as will be explained under Discussion. Because it was an open ended question, it was difficult to break responses into percentages. Few women felt improvements were necessary.
PERCENTAGE BAR CHART

PERCENTAGE

50
40
30
20
10

V E R Y S A T I F I E D S O M E W H A T S A T I F I E D N O T

SATISFACTION WITH CARE

V37

Chart 12
Waiting Time during appointments  Most women were satisfied with the waiting time at the clinic, saying that considering the fact that there were so many patients to be seen, only the initial appointment was long. 91% said that they had to wait less than one hour to be seen by the physician, with only 9% complaining that they had to wait over one hour.

Table 15 shows the frequencies connected with waiting time.

<table>
<thead>
<tr>
<th>WAITING TIME AT CLINIC</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>LESS THAN 30 MIN</td>
<td>21</td>
<td>21</td>
<td>60.000</td>
<td>60.000</td>
</tr>
<tr>
<td>UP TO 1 HOUR</td>
<td>11</td>
<td>32</td>
<td>31.429</td>
<td>91.429</td>
</tr>
<tr>
<td>OVER 1 HOUR</td>
<td>3</td>
<td>35</td>
<td>8.571</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 15

Conflicts with Clinic Appointments  As mentioned above, most of the women (91.4%) did not feel there were conflicts, in comparison with 8.5% who did, as shown below, Table 16.

<table>
<thead>
<tr>
<th>CONFLICTS WITH CLINIC APPOINTMENTS</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>3</td>
<td>3</td>
<td>8.571</td>
<td>8.571</td>
</tr>
<tr>
<td>NO</td>
<td>32</td>
<td>35</td>
<td>91.429</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 16
Sex of Health Provider  Two questions dealt with this variable:

Sex of Physician Preferred: The majority of the women, 71.4% prefer to be seen by a female physician, 23% said that the sex of the doctor was of no concern to them, but only 6% preferred to be seen by a male doctor. (Table 17)

<table>
<thead>
<tr>
<th>SEX OF PHYSICIAN PREFERRED</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEMALE PHYSICIAN</td>
<td>25</td>
<td>25</td>
<td>71.429</td>
<td>71.429</td>
</tr>
<tr>
<td>MALE PHYSICIAN</td>
<td>2</td>
<td>27</td>
<td>5.714</td>
<td>77.143</td>
</tr>
<tr>
<td>EITHER SEX</td>
<td>8</td>
<td>35</td>
<td>22.857</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 17

Women were asked whether they were usually seen by a male or a female physician—Sex of Examining Physician: 69% are usually seen by a female doctor, 20% by a male doctor, and 11.4% said they are seen by either a male or female. (Table 18)

<table>
<thead>
<tr>
<th>SEX OF EXAMINING PHYSICIAN</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEMALE PHYSICIAN</td>
<td>24</td>
<td>24</td>
<td>68.571</td>
<td>68.571</td>
</tr>
<tr>
<td>MALE PHYSICIAN</td>
<td>7</td>
<td>31</td>
<td>20.000</td>
<td>88.571</td>
</tr>
<tr>
<td>EITHER SEX</td>
<td>4</td>
<td>35</td>
<td>11.429</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 18
Clarity of Instructions. This is the variable that elicited some positive answers from the majority of the respondents. Several questions were asked. The first one was, "Are the instructions given to you at the clinic usually clear?" While 74% answered affirmatively, 20% said sometimes; while only 6% said they could not understand instructions. (Table 11)

<table>
<thead>
<tr>
<th>V20</th>
<th>CLARITY OF INSTRUCTIONS</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td></td>
<td>26</td>
<td>26</td>
<td>74.286</td>
<td>74.286</td>
</tr>
<tr>
<td>NO</td>
<td></td>
<td>2</td>
<td>28</td>
<td>5.714</td>
<td>80.000</td>
</tr>
<tr>
<td>SOMETIMES</td>
<td></td>
<td>7</td>
<td>35</td>
<td>20.000</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 19

Who Explains Instructions? The advantages of employing bilingual/bicultural personnel at WWH's clinic are confirmed on Table 20, Chart 13. The clinic assistants/aides—"las muchachas"—are singled as the most important source of information at the clinic, followed individually by bilingual relatives, friends, neighbors, and husbands—as a special category. Nurses and physicians each only contributed 8.5% of the explanations, followed by own/self-explanation, or 3%.

<table>
<thead>
<tr>
<th>V29</th>
<th>WHO EXPLAINS INSTRUCTIONS?</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURSES</td>
<td></td>
<td>3</td>
<td>3</td>
<td>8.571</td>
<td>8.571</td>
</tr>
<tr>
<td>PHYSICIANS</td>
<td></td>
<td>3</td>
<td>6</td>
<td>8.571</td>
<td>17.143</td>
</tr>
<tr>
<td>CLINIC ASSISTANT</td>
<td></td>
<td>12</td>
<td>18</td>
<td>34.286</td>
<td>51.429</td>
</tr>
<tr>
<td>SISTER</td>
<td></td>
<td>4</td>
<td>22</td>
<td>11.429</td>
<td>62.857</td>
</tr>
<tr>
<td>BILING RELATIVES</td>
<td></td>
<td>5</td>
<td>27</td>
<td>14.286</td>
<td>77.143</td>
</tr>
<tr>
<td>BILING FRIENDS/N</td>
<td></td>
<td>3</td>
<td>30</td>
<td>8.571</td>
<td>85.714</td>
</tr>
<tr>
<td>MYSELF</td>
<td></td>
<td>1</td>
<td>31</td>
<td>2.857</td>
<td>88.571</td>
</tr>
<tr>
<td>HUSBAND</td>
<td></td>
<td>4</td>
<td>35</td>
<td>11.429</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 20
PERCENTAGE BAR CHART

PERCENTAGE

30

25

20

15

10

5

NURSES

PHYSICIANS

CLINIC

SISTER

BILLING

BILLING

SELF

HUSBAND

NID EXPLAINS INSTRUCTIONS?

Chart 13
Awareness of Appointments and Procedures: The majority of women (83%) said that they knew they had an appointment for a specific date and procedure/treatment, 11.4% said that they were only aware of having an appointment but did not know for what procedure, and 6% said that they were not aware of having either a prenatal care appointment or procedure. (Table 21, Chart 14).

<table>
<thead>
<tr>
<th>APPT &amp; PROCED</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ONLY APPOINTMENT</td>
<td>29</td>
<td>29</td>
<td>82.857</td>
<td>82.857</td>
</tr>
<tr>
<td>NEITHER</td>
<td>2</td>
<td>35</td>
<td>5.714</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 21

Readability of Printed Materials: Upon receiving conflicting answers from some individuals, it was ascertained that the question was incomplete. When the phrase "if in Spanish" was added 26% of the women said they could read the materials; otherwise they would have joined the 3% who said that they could read the materials only sometimes. The majority (71.4%) said they could read the printed materials distributed at the clinic. As will be discussed later, maybe the definition of "reading" should be operationally defined, particularly in view of the fact that health materials are usually written at higher levels of reading than the average printed material. (Table 22, Chart 15)

<table>
<thead>
<tr>
<th>READABILITY OF PRINTED MATERIALS</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>25</td>
<td>25</td>
<td>71.429</td>
<td>71.429</td>
</tr>
<tr>
<td>SOMETIMES</td>
<td>1</td>
<td>26</td>
<td>2.857</td>
<td>74.286</td>
</tr>
<tr>
<td>ONLY IF IN SPANISH</td>
<td>9</td>
<td>35</td>
<td>25.714</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 22
AWARENESS OF APPT AND PROCEDURES?

Chart 14
READABILITY OF MATERIALS

Chart 15
Personal Characteristics

Person in Family Responsible for Health Decisions: Although it seems that "own decision" (48.6%) is the majority choice, relatives (42.9%) and friends/neighbors (5.7%) also have significant impact on health decisions. This factor must be taken into consideration when treating Puerto Rican patients, as mentioned under Discussion. (Table 23)

<table>
<thead>
<tr>
<th>WHO HELPS YOU DECIDE ON HEALTH?</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>OWN DECISION</td>
<td>17</td>
<td>17</td>
<td>48.571</td>
<td>48.571</td>
</tr>
<tr>
<td>RELATIVES</td>
<td>15</td>
<td>32</td>
<td>42.857</td>
<td>91.429</td>
</tr>
<tr>
<td>FRIENDS/NEIGHBOR</td>
<td>2</td>
<td>34</td>
<td>5.714</td>
<td>97.143</td>
</tr>
<tr>
<td>AGENC/INSTIT</td>
<td>1</td>
<td>35</td>
<td>2.857</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 23

Who Suggested WWH? This question was related to the previous one and more amply illustrates the influence of significant others, including a category called "word of mouth." Only 26% of the sample relied on their own decision, 60% were influenced by the suggestion of relatives, friends/neighbors, 8.6% relied on word of mouth, and 5.7% followed the suggestion of agencies or institutions. (Table 24)

<table>
<thead>
<tr>
<th>WHO SUGGESTED WESSON CLINIC?</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>OWN DECISION</td>
<td>9</td>
<td>9</td>
<td>25.714</td>
<td>25.714</td>
</tr>
<tr>
<td>RELATIVES</td>
<td>15</td>
<td>24</td>
<td>42.857</td>
<td>68.571</td>
</tr>
<tr>
<td>FRIENDS/NEIGHBOR</td>
<td>6</td>
<td>30</td>
<td>17.143</td>
<td>85.714</td>
</tr>
<tr>
<td>WORD OF MOUTH</td>
<td>3</td>
<td>33</td>
<td>8.571</td>
<td>94.286</td>
</tr>
<tr>
<td>AGENC/INSTIT</td>
<td>2</td>
<td>35</td>
<td>5.714</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 24
Number of Children Patient is Responsible for: Six women (17%) of the sample did not have any children; 28.6% had 1; 37% had 2; 11% had 3; and 6% had 4 children. These findings in the sample conflicted with expected number of children mentioned in the hypothesis. (Table 25, Chart 16)

Ages of children: Responses fluctuated between the ages of 7 months to 11 years.

Children to Five Years Old Living with Patient: Table 26, Chart 17, indicate that 31.4% had no children ages 5 or under, 28.6% had 1; 31.4% had 2 and 9% had 3 children five years and under. Therefore, more than two-thirds of the sample had children five years old and under at home.

Availability of Child Care: When asked if it was difficult to make arrangements for child care when having clinic appointments, 37% said yes, 60% said no, and 3% said sometimes. This is because most women either take children with them to their appointments or rely on their families, friends/neighbors for child care. (Table 27 - Child Care Arrangement Problems)

<table>
<thead>
<tr>
<th>CHILDCARE ARRANG PROBLEMS?</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>13</td>
<td>13</td>
<td>37.143</td>
<td>37.143</td>
</tr>
<tr>
<td>NO</td>
<td>21</td>
<td>34</td>
<td>60.000</td>
<td>97.143</td>
</tr>
<tr>
<td>SOMETIMES</td>
<td>1</td>
<td>35</td>
<td>2.857</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 27

Preferred Language for Reading Materials: A surprising 46% stated that they preferred to read in English, 43% preferred to read in Spanish, and 11% in either language. (Table 28, Chart 18). This certainly was not correlated to
<table>
<thead>
<tr>
<th>NUMBER OF CHILDREN LIVING WITH YOU / RESPONSIBLE FOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>FREQUENCY</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
</tbody>
</table>

Table 25

PERCENTAGE BAR CHART

NUMBER OF CHILDREN LIVING WITH YOU / RESPONSIBLE FOR

Chart 16
<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Cum Freq</th>
<th>Percent</th>
<th>Cum Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO CHILDREN</td>
<td>11</td>
<td>11</td>
<td>31.429</td>
<td>31.429</td>
</tr>
<tr>
<td>1 CHILD</td>
<td>10</td>
<td>21</td>
<td>20.571</td>
<td>60.000</td>
</tr>
<tr>
<td>2 CHILDREN</td>
<td>11</td>
<td>32</td>
<td>31.429</td>
<td>91.429</td>
</tr>
<tr>
<td>3 CHILDREN</td>
<td>3</td>
<td>35</td>
<td>8.571</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 26

**Percentage Bar Chart**

<table>
<thead>
<tr>
<th>PERCENTAGE</th>
<th>11</th>
<th>10</th>
<th>11</th>
<th>11</th>
<th>11</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Chart 17
IN WHAT LANGUAGE DO YOU PREFER TO READ?

Chart 18
either language preferred for interview (Table 1, Chart 1) or to readability of printed materials (Table 20).

<table>
<thead>
<tr>
<th>LANGUAGE</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPANISH</td>
<td>15</td>
<td>15</td>
<td>42.857</td>
<td>42.857</td>
</tr>
<tr>
<td>ENGLISH</td>
<td>15</td>
<td>31</td>
<td>45.714</td>
<td>88.571</td>
</tr>
<tr>
<td>EITHER</td>
<td>4</td>
<td>35</td>
<td>11.429</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 28

Can you Read in English? In order to ascertain the degree of literacy in English, questions on reading, writing and comprehension in both English and Spanish were included in the bilingual questionnaire. Table 29 shows that 80% of the sample said they could read English, 9% could not, and 11% said they could read a little in English.

<table>
<thead>
<tr>
<th>READ ENGLISH?</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>23</td>
<td>23</td>
<td>65.714</td>
<td>65.714</td>
</tr>
<tr>
<td>NO</td>
<td>6</td>
<td>29</td>
<td>17.143</td>
<td>82.857</td>
</tr>
<tr>
<td>A LITTLE</td>
<td>6</td>
<td>35</td>
<td>17.143</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 29

Can you Understand what you Read in English? The answer seems to indicate that there is a need for a definition of "reading" since considerably fewer women said they could understand what they read in English (66%), 17% said they could not understand, and 17% said they could understand a little. (Table 30)

<table>
<thead>
<tr>
<th>UNDERSTAND WHAT YOU READ IN ENGLISH?</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>23</td>
<td>23</td>
<td>65.714</td>
<td>65.714</td>
</tr>
<tr>
<td>NO</td>
<td>6</td>
<td>29</td>
<td>17.143</td>
<td>82.857</td>
</tr>
<tr>
<td>A LITTLE</td>
<td>6</td>
<td>35</td>
<td>17.143</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 30
Can you Write in English? Compared to reading in English, a lower percentage (54%) said they could write English, while 29% said they could not, and 17% stated they could write a little. (Table 31)

<table>
<thead>
<tr>
<th>WRITE IN ENGLISH?</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>19</td>
<td>19</td>
<td>54.286</td>
<td>54.286</td>
</tr>
<tr>
<td>NO</td>
<td>10</td>
<td>29</td>
<td>28.571</td>
<td>82.857</td>
</tr>
<tr>
<td>A LITTLE</td>
<td>6</td>
<td>35</td>
<td>17.143</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 31

Questions on reading, comprehension, and writing in Spanish follow.

Can you Read in Spanish? The majority of the women (86%) said they could, 6% said they did not know how to read in Spanish, and 8% said that they could read a little. (Table 32)

<table>
<thead>
<tr>
<th>READ SPANISH?</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>30</td>
<td>30</td>
<td>85.714</td>
<td>85.714</td>
</tr>
<tr>
<td>NO</td>
<td>2</td>
<td>32</td>
<td>5.714</td>
<td>91.429</td>
</tr>
<tr>
<td>A LITTLE</td>
<td>3</td>
<td>35</td>
<td>8.571</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 32

Can you Understand what you Read in Spanish? The majority of the respondents (80%) said they could, 6% said they could not read in Spanish and 14% said they could read a little. This last group mentioned that they had problems in understanding "big" words in Spanish. (Table 33)

<table>
<thead>
<tr>
<th>UNDERSTAND WHAT YOU READ IN SPANISH?</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>28</td>
<td>28</td>
<td>80.000</td>
<td>80.000</td>
</tr>
<tr>
<td>NO</td>
<td>2</td>
<td>30</td>
<td>5.714</td>
<td>85.714</td>
</tr>
<tr>
<td>A LITTLE</td>
<td>5</td>
<td>35</td>
<td>14.286</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 33
Can you Write in Spanish? 77% of the sample said that they could write in Spanish, 9% could not, and 14% said they knew some (a little). Table 34 illustrates the answers.

<table>
<thead>
<tr>
<th>WRITE IN SPANISH?</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>27</td>
<td>27</td>
<td>77.143</td>
<td>77.143</td>
</tr>
<tr>
<td>NO</td>
<td>30</td>
<td>30</td>
<td>8.571</td>
<td>85.714</td>
</tr>
<tr>
<td>A LITTLE</td>
<td>35</td>
<td>35</td>
<td>14.286</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 34

The implications of these findings will be mentioned under Discussion.

Stated Reasons for Missing Scheduled Appointments:

Although this variable was placed under Personal Characteristics, the answers indicate that most reasons for non-complying with scheduled appointments may fall under Structural variables. In fact, Table 35 below indicates that over 45% of the respondents gave structural reasons for their non-compliance: 11.4% for financial/insurance, 14.3% because of inadequate clinic hours, 20% for simultaneous appointments in other areas of the hospital--while the rest fell in-between personal and structural reasons. A review

<table>
<thead>
<tr>
<th>REASONS FOR NONCOMPLIANCE</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>FINAN/INSURANCE</td>
<td>4</td>
<td>4</td>
<td>11.429</td>
<td>11.429</td>
</tr>
<tr>
<td>LACK OF TRANSPORT</td>
<td>3</td>
<td>7</td>
<td>8.571</td>
<td>20.000</td>
</tr>
<tr>
<td>LACK OF CHILD CA</td>
<td>2</td>
<td>9</td>
<td>5.714</td>
<td>25.714</td>
</tr>
<tr>
<td>INADEQ CLINIC HO</td>
<td>5</td>
<td>14</td>
<td>14.286</td>
<td>40.000</td>
</tr>
<tr>
<td>SICK CHILD/SELF</td>
<td>7</td>
<td>21</td>
<td>20.000</td>
<td>60.000</td>
</tr>
<tr>
<td>SIMULTANEOUS APP</td>
<td>7</td>
<td>28</td>
<td>20.000</td>
<td>80.000</td>
</tr>
<tr>
<td>FORGOT</td>
<td>5</td>
<td>33</td>
<td>14.286</td>
<td>94.286</td>
</tr>
<tr>
<td>OTHER</td>
<td>2</td>
<td>35</td>
<td>5.714</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 35
of the different components of this variable and of its inter-
relationship with demographic, structural, and personal charac-
teristics is given under Discussion. (Chart 19)

**Self-Reminder Methods Used by Patients:** Table 36

shows that 49% of the respondents mentioned the calendar
as their main source of remembering scheduled appoint-
ments, followed by the appointment card given at the clinic
(29%, both (17%) and nothing, 5%.

<table>
<thead>
<tr>
<th>METHODS TO RECORD APPTS</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARD</td>
<td>10</td>
<td>10</td>
<td>28.571</td>
<td>28.571</td>
</tr>
<tr>
<td>CALENDAR</td>
<td>17</td>
<td>27</td>
<td>48.571</td>
<td>77.143</td>
</tr>
<tr>
<td>BOTH</td>
<td>3</td>
<td>30</td>
<td>8.571</td>
<td>85.714</td>
</tr>
<tr>
<td>OTHER</td>
<td>5</td>
<td>35</td>
<td>8.571</td>
<td>94.286</td>
</tr>
<tr>
<td>NOTHING</td>
<td>2</td>
<td>33</td>
<td>5.714</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 36

A previous question, **Do you Use your Appointment Card?** had yielded an 80% affirmative response, with 17% of the sample saying that they did not use their cards, and 3% saying they used them sometimes. In an effort to confirm the usefulness of the appointment cards the women were then given a choice of a reminder, and the calendar was suggested. Table 37 shows the answers to the use of appointment cards.

<table>
<thead>
<tr>
<th>DO YOU USE APPOINTMENT CARDS?</th>
<th>FREQUENCY</th>
<th>CUM FREQ</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>28</td>
<td>28</td>
<td>80.000</td>
<td>80.000</td>
</tr>
<tr>
<td>NO</td>
<td>6</td>
<td>34</td>
<td>17.143</td>
<td>97.143</td>
</tr>
<tr>
<td>SOMETIMES</td>
<td>1</td>
<td>35</td>
<td>2.857</td>
<td>100.000</td>
</tr>
</tbody>
</table>

Table 37
PERCENTAGE BAR CHART

18
15
12
9
6
3

FINANCE
LACK
OF
TRANSPORT
LACK
OF
CHILD
CA
INADEQUATE
CLINIC
SICK
CHILD
SELF
SIMULTANEOUS
APP
FORGOT
OTHER

REASONS FOR NONCOMPLIANCE

Chart 19
Beliefs in the Hot-Cold Theory: Throughout the literature on the health of Hispanics and on Puerto Ricans in particular, there are references to beliefs regarding the nature of foods and medications as "hot" or "cold." The implications for public health seemed very valuable. However, the majority of respondents (83%) seemed to have no knowledge of this custom, while 17% said they did. (Table 38)

<table>
<thead>
<tr>
<th>V38</th>
<th>BELIEFS IN HOT/COLD THEORY?</th>
<th>FREQUENCY</th>
<th>CUM FREQUENCY</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>6</td>
<td>6</td>
<td>17.143</td>
<td>17.143</td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td>29</td>
<td>35</td>
<td>82.857</td>
<td>100.000</td>
<td></td>
</tr>
</tbody>
</table>

Table 38

One more question on Hot/Cold Theory Examples was asked. Although a few more women seemed to know some instances where hot and cold food and medications were used as "folk medicine"--lemons and oranges are cold; therefore, they may not be eaten when one has a cold--this variable did not show the promised value. While 86% of the women could not give any examples, 14% remembered some. (Table 39)

<table>
<thead>
<tr>
<th>V39</th>
<th>HOT/COLD THEORY EXAMPLES?</th>
<th>FREQUENCY</th>
<th>CUM FREQUENCY</th>
<th>PERCENT</th>
<th>CUM PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>5</td>
<td>5</td>
<td>14.286</td>
<td>14.286</td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td>30</td>
<td>35</td>
<td>85.714</td>
<td>100.000</td>
<td></td>
</tr>
</tbody>
</table>

Table 39

As stated in the beginning of this Data Analysis, the most important variables will be explained under Discussions, with some references to the current literature.
Discussion of Variables and Assumptions

This descriptive study of compliance among 35 pregnant Puerto Rican women at Wesson Women's Unit (WWU) of Baystate Medical Center (BSMC) in Springfield, Massachusetts divided the variables of the Bilingual Questionnaire into three categories: demographic, structural/organizational, and personal characteristics of the patients. Assumptions were made concerning the nature of non-compliance with scheduled appointments because of patient's characteristics. However, a review of the responses to the Bilingual Questionnaire suggests that the structural/organizational variables may have acted as the most potent barriers to compliance.

Some salient factors that have added to the interest of this descriptive study have been connected with the educational background of the participants, trimester of entry, availability of transportation, and financial problems. These variables will be discussed in connection with structural factors that may need reconsideration.

Although the results of the study may not be generalized to the whole clinic population of non-compliant patients, it may certainly function as a strong basis from which to develop a larger and more elaborate investigation in the near future.

It must be stated at the beginning of this discussion that warm feelings of appreciation towards WWU and its clinic
personnel--specially to the health aides/medical assistants and nutritionists--were expressed by the majority of the participants. Thus, assumption No. 11 was upheld.

Since this very important clinic asset of WVU which is structural, it may be said that patients' positive perception of treatment allows a constructive criticism of apparent flaws in the clinic environment. It also promises to facilitate some changes in organizational procedures which may make it easier for pregnant Puerto Rican women to keep appointments in the future.

Another factor of importance that has not been considered a variable is the telephone. Not all patients have a phone, specially poor Puerto Rican patients attending WWU clinics. That is one of the main reasons why close to one third of the non-compliant patients (individuals who failed to attend their scheduled appointments one or more times) could not be included in the project. An alternate method of outreach than the phone must be considered, taking into consideration that written messages are not always acknowledged either because of language problems or because of the high mobility of Puerto Ricans within the city of Springfield and the island of Puerto Rico. Therefore, the first two assumptions concerning the phone were supported in this study.

A discussion of the three categories of variables follows, closely identified with the format of the Analysis of Data.
**Language Preference for Interview:** Chart 1 demonstrates the preponderance of Spanish in the sample. More than half (57%) chose Spanish, while 23% could function in either language, and 20% chose English. Monoligualism of the non-compliant population does not seem to be an issue in this study. However, as the telephone interview progressed, other questions related to language elicited conflicting information about proficiency. It may be that "language loyalty" rather than inability to speak English may be confusing the language performance.

**Demographic Variables**

**Birthplace:** This question was necessary in order to eliminate any non-Puerto Rican Hispanics from the sample for validity purposes. Chart 2 indicates that close to one third of the sample was born in continental United States. However, the women still declared themselves Puerto Rican, as will be seen below.

**Self-Identification of Hispanic Heritage:** This question confirmed the literature claims (Alers, 1978; Badillo-Ghali, 1977; Delgado, 198; Fitzpatrick, 1971) concerning the tendency of Puerto Ricans to identify themselves as PRs regardless of their birth, length of stay or generation in the USA. Studies of "Puerto Ricans" will not be able to differentiate between those born in the island or the mainland (USA). Only
2.9% declared themselves to be both American and Puerto Rican. It seemed like a repetitive question, but it upheld the findings in the literature review about ethnicity and Puerto Ricans in the United States.

**Age, Marital Status, Trimester of Entry and Occupation:**

The combination of these variables seem to place most of the women in the sample in a potentially precarious situation as young, single parents, female heads of household, probably with limited social and economic resources. The highest percentage of mothers-to-be was among the ages of 20 to 25 years of age (Chart 4); only 30% were married (Chart 5), and only 49% of the sample (Chart 6) entered in the first trimester of pregnancy.

Perhaps the most crucial variable in this combination is the trimester of entry, since many problems for both mother and infant may be prevented in this critical stage.

Considering that 80% of the women were housewives, it becomes clear that there is a need for more outreach programs and social work supportive services at the hospital in order to foster earlier entry into prenatal care.

**Length of Residence in Springfield:** The mobility of young Puerto Rican families within the cities, states, and the island has been discussed in the literature review under Puerto Ricans. This migratory problem is connected with telephone disconnections, lack of phones because of lack of funds and/or constant moves, and problems with continuity of
health care. Chart 7 illustrates the number of years of residence in Springfield, with more than 50% of the sample living in Springfield less than six years, and 21% living in the city a year or less. Two women commuted from Holyoke, and one from Chicopee. (Table 7)

Place of Education: Puerto Rico was the place of education for most of the sample. The implications for this community is that perhaps it is time to make more connections with the island. Springfield schools must become more cognizant with the curriculum in Puerto Rico so that there may be remedial problems suited to both locations. Naturally, this is closely related to the next variable.

Years of Study: It was surprising to the investigator to find that 37% of the sample had reached between the 10th and 12th grades. This certainly seems to be a local trend, not supported by the review of literature on the education of Puerto Ricans, particularly those of the lower socio-economic group. What is more important to me is the fact that something seems to happen in the 9th grade. Forty percent reached the 9th grade and dropped out. (Arbitrarily, the categories were divided in such a way as to emphasize the fateful 9th grade).

Education of the mother is linked to lower birth weights, higher infant and child morbidity and mortality, teen age pregnancies, welfare, school dropouts, poverty, alcohol and drug abuse, and child abuse (Barlow, 192; Ca-
nino and Canino, 1980; Cochran et al 1982; Drifoos, 1983; Fernandez-Pol, 1980; Mare, 1982; Starfield, 1982). These findings must be shared with educators and clients alike so that young women become more informed of the dangers of dropping out of school, and teachers may undertake more strategies to prevent dropouts.

In my work at a local community college, I plan to share this very important variable with my colleagues and students.

**Present Occupation:** Since most women are housewives, possible conflicts with clinic appointments and waiting periods may not seem to be issues for non-compliance. However, as will be seen in the next variables, it cannot be assumed that just because the women in the sample are mostly housewives, they have no child care problems. Some do have problems and special arrangements must be made to service those women in need.

**Structural Variables**

**Accessibility to the Clinic:** The problems of accessibility and utilization of health care services are of great concern to both patients and institutions alike. Problems in scheduling appointments and waiting at the doctors' offices are the access issues of serious concerns (Thomas and Penchansky, 1984). There seems to be a relationship between accessibility and cultural differences among ethnic groups.
Furthermore, system-related/structural factors may be actual barriers to utilization of health services and non-compliance (Tangerose, Miller, and Sherman, 1984).

**Types of Transportation Used, Difficulty in Getting to the Clinic, and Distance to the Clinic:** It must be emphasized that although most of the women said that the clinic distance was not too far (51.3%), the majority of the sample walked (49.5%, Table 12). Walking is easier and cheaper than taking the bus, but as the pregnancy progresses, walking becomes more difficult. In addition, many women have to take small children with them. That is when they must decide to miss their appointments and become non-compliant.

The monolingual women talked about their difficulties using the buses because they could not understand the directions, all of which are printed or verbalized in English only. Bus drivers could learn some phrases in Spanish to allay the fears of their passengers. Using bilingual printed materials bus drivers could be doing some health promotion by helping the women to be more self-reliant and not miss their appointments on account of transportation.

**Clinic Environment:** Only two women (6%) of the sample were not satisfied with the service. Eventually one of them left the system and went to a private practitioner. She had had problems with financial matters. However, the majority of the respondents said the clinic was "muy chevere" (very
nice) and the health aides and medical assistants very friendly. In particular, the participants praised the nutritionists.

**Waiting Time During Appointments:** This was not considered a problem. However, it seems possible to lessen the waiting time for an appointment card. Women stated that the delays were many times due because attendants were busy with clerical chores. Waiting for the physician was not the problem. Sometimes it took longer to get the date for the appointment. Delegating this task to one of the aides may solve this waiting problem.

**Conflicts with Clinic Appointments:** As stated before under Occupation, the fact that most women are housewives lessens potential conflicts with clinic hours. However, as will be discussed under Reasons for Non-Compliance (Table 35, some women mentioned inadequate clinic hours, conflicting with bus schedules, resting periods during pregnancy, and children's medical appointments. More flexibility, specially in the morning schedules may be advisable.

**Readability of Printed Materials:** The fact that women in the sample said they could "read" the printed material did not mean they could understand it. As has been mentioned in the section on illiteracy, most health materials are written for readers at college level. In order to understand the message, local materials should be prepared using simple and short messages to allow instructions to be
followed. The fact that 80% of the respondents said they could read in English but 66% could understand what they read may suggest that some of these women may be performing at the level of "functional illiterates" (Kozol, 1980; Grudner, 1981). Health education materials must reflect the needs of patients, specially the monolingual Spanish-speaking individuals who may benefit from bilingual/bicultural printed materials.

**Personal Characteristics**

**Person in Family Responsible for Health Decisions:**

The influence of the family on health matters is not only based on regard for the elders and respect for adults in the society, but also on financial and social supports. There is an interdependence between the individual and his/her family that makes health a "family affair." Asking the patient to "make a decision" may not be as easy among Hispanic groups and subgroups. Health professionals must be aware of this cultural tradition and involve the family in the treatment of a patient. Because of migration patterns among many Puerto Ricans, friends and neighbors become the network of support—the adopted relatives—and their input is as valuable as that of true blood relatives. This custom may be observed in patterns of child care. "Baby-sitting" is alien to the culture. It is a family tradition
that is undertaken without expectations of remuneration. Friends, neighbors, and relatives are available for child care. When this is not possible, then children must be taken by the parents to their appointments. This is the reason why in spite of the fact that two-thirds of the women in the sample had children five years old and under at home, 60% said they had no problems of child care.

**Preferred Language for Reading Materials:** It certainly was unexpected to learn that 46% of the sample preferred to read in English, 11% in either language (which would make it a total of 57% in English) and 43% in Spanish. But it was even more surprising to learn that 80% of the sample declared themselves capable of reading English. Perhaps the answer to this contradiction to my assumption is that when the question on comprehension was raised, then only 66% of the sample could comprehend what they read—as stated under "Readability of Printed Materials."

The rest of the questions on reading, comprehending, and writing in Spanish were asked in order to ascertain the level of literacy of the sample. At least on paper it seems that this group was more evenly represented educationally. The fact that most women were literate in English and/or Spanish made it easier to become proficient in English. My hypothesis was not upheld with this group.
Stated Reasons for Non-Compliance: A review of the literature of non-compliance reveals a multifactorial nature of the problem in health care settings. The numerous investigations and studies list hundreds of variables that may be considered barriers to compliance. Factors mentioned include age, race, language, culture, occupation, income, rurality, urbanity, migration, pain, anxiety, cost, work schedules, transportation, embarrassment from public display or from insertion of instruments, long waiting periods, and many others. Becker (1976) explains the severity of the problem as follows:

In attempting both to discover and better understand the determinants of patient compliance behavior, hundreds of investigations have been undertaken, ranging in emphasis from medical and economic considerations to dimensions which are mainly demographic, socioeconomic, sociocultural, personal and motivational, geographic, organizational, and social-interactive...

(p. 96)

Perhaps in the case of some poor Puerto Rican patients the barriers of culture and language increase the probability of non-complying with appointed schedules. However, findings are unanimous in showing that non-compliance is almost universal and cannot be explained as a characteristic of any particular personality type or group (Becker, 1976; Hayes-Bautista, 1976; Rotter, 1977; Haynes, 1982).
Depending on the treatment and the type of lifestyle change involved, non-compliance with scheduled appointments ranges from 10% to 50% (Gunter-Hunt, 1983; Hertz and Stamps, 1977; Morse et al., 1984).

Since the health needs of populations vary from region to region, especially in this multicultural, multi-ethnic USA, the characteristics of the local population must be taken into consideration. Therefore, a discussion of the variables involved in the non-compliance of the 35 women, as stated by the respondents.

Financial/Insurance: Table 35 shows that 11.4% of the sample complained of financial problems. Qualitative analysis of the data indicates that women experienced frustration, anxiety, embarrassment and anger because bills would arrive at their homes—sometimes every two weeks—asking for amounts ranging between $500 and $900. Conversations with clinic administrative personnel have disclosed the fact that WWU does not discuss financial aspects with patients unless the women ask for an explanation. As Mechanic (1968) has stated, most clinic patients do not have the sophistication of other health consumers. Rather than expect the patient to request complicated financial information, there must be a person at the clinic assigned to explain financial duties and benefits to the patients. There is a flaw in the
The clinic's policies and procedures that must be corrected as soon as possible. Because most women at the clinic seem to be covered by Medicaid, it was assumed that few financial problems would exist. This data contradicts that assumption.

Lack of Transportation: 8.6% of the sample complained about the lack of transportation. Although living within walking distance, because of pregnancy demands, young children, weather conditions, and lack of communication with bus drivers, some women opt for staying home and become non-compliant. Either a brochure in Spanish or learning some phrases in Spanish may allow bus drivers to help monolingual Hispanic women passengers.

Lack of Child Care: One incident occurred with a participant and child care. After I called her to keep her appointment she left a 9 year old baby sitter and may have experienced difficulties with a visiting nurse. Some type of arrangement must be developed in order that pregnant women with small children may be free to attend their appointments without further anxieties. Assumption upheld.

Simultaneous Appointments: This was another interesting finding. In this age of computers it might seem that the clinic personnel would have access to electronic devices which would allow them to monitor appointments scheduled in the various departments of a single hospital. Many of the
women approaching delivery have false labor pains and must have mini stays at the hospital while scheduled for clinic appointments. At other times, their children are given appointments in other departments of the Medical Center and preference/priority is given to the children's appointment. Still other times, the patients are sent for procedures connected with their pregnancies and must go to other areas of the hospital. These simultaneous appointments can be avoided through better monitoring.

**Inadequate Clinic Hours:** 14.3% of the women complained that as a result of sleepless nights--due to the pregnancies--they had difficulty in getting up early in the morning, walk or take two busses, and be at the clinic before 9:00 a.m. Efforts to persuade clinic personnel to allow the patients to be examined after 10:30 a.m. seemed to go unheeded. Pregnant women should be given more flexible appointments.

**Sick Child or Self:** 20%: This is a combination of priorities for child care and pregnancy problems discussed before.

**Forgot:** Not a structural problem. However, a clinic reminder shortly before the appointment might be helpful.

**Other:** 5.6% - Added to the above 14.3% because of forgetfulness, a total of 19.9% is not structural, while a total of 81.1% may be attributable to structural factors.
Beliefs in the Hot-Cold Theory: In spite of the frequent references in the literature (Harwood, 1971; Rodriguez-Dorsey and Quintero-Jackson, 1976; Saunders, 1954) about the popularity of the Hot and Cold Theory of foods and medications, 82.9% had no knowledge of this custom. As to examples on practices of the Hot and Cold Theory among members of their families or friends—maybe using herbs, medications or frequenting local "botanicas" (specialty shop where herbs, potions, idols, incense, rosaries and remedies are sold)—85.7% denied any knowledge or connection with folk remedies. Only 14.2% spoke about herbal teas and home remedies when having chest or head colds. There was some allusion to the "cold" nature of orange juice ("jugo de china") not recommended in cases of head or chest colds. However, most of the answers on the benefits of folk medicine were actual sneers against "superstitions" and "backward" ideas of "ignorant or very simple people." Perhaps with a larger group or an older group there might be more references to the Hot and Cold Theory among Puerto Rican patients.

Finally, a qualitative question was asked the participants requesting suggestions to improve the present services at the clinic. As was explained at the beginning of this discussion, the women in the sample praised the performance of the clinic medical assistants/aides and nutritionists.
Few suggestions were given. Responses ranged from the very polite, "Nothing. Everything is fine," to requests for more female doctors; strong demands for more privacy while being examined; more explanations on financial rights and responsibilities for patients; and more flexible morning hours for clinic tests and exams. There was also an interesting suggestion to refrain from using "too much material in Spanish at the clinic; otherwise women will never learn to stand on their two feet, unless those Spanish instructions and aides are removed." That was the first time that I had heard any negative comments about the clinic's bilingual/bicultural resources during close to fifteen years of association with Wesson Women's Unit. Since only one person made that comment, it may be overlooked. Ironically, it was a Hispanic who made the remark.

The Conclusion and Recommendations for this Descriptive Study follow. I hope to continue working with WWU and its patients for many more years.
Conclusion

Throughout this dissertation, the need for local, valid, reliable studies dealing with Puerto Rican patients has been considered crucial. The Descriptive Study just reviewed has fulfilled that need, defining the population: clinic patients; the Hispanic sub-group: Puerto Rican; their common health condition: pregnancy, and the objectives of the research: finding the reasons for patient non-compliance with scheduled appointments.

As was mentioned in the Discussion of Variables and Assumptions, this descriptive study at Wesson Women's Unit (WWU) of Baystate Medical Center (SMC) in Springfield, Massachusetts, has revealed the need for the revision of some structural/organizational (clinic) procedures. Assumptions made at the beginning of the study were actually "guesstimates" of what most health professionals expected to find—including this researcher. It was surprising, therefore, to learn that at a progressive hospital like WWU there is presently a serious flaw dealing with finances. It seems that unless Puerto Rican patients inquire about their financial obligations and rights as Medicaid patients, clinic personnel seem to assume that the patients know their situation. Meanwhile, there are indications—from the study—that many non-compliant behaviors are due to fear of more billing.
An unexpected finding directly related to clinic policy, is the fact that more training of clinic personnel is needed to take information and personal data. The fact that most of the clinic personnel is bilingual/bicultural does not compensate for some learning experiences that are seldom internalized unless professional training is offered.

An important feature that was expected by this researcher but was not found throughout the review of the literature of non-compliance is the telephone. Clinic women and clerical personnel made mistakes in giving and recording telephone numbers. It must be a policy to request at least three phone numbers of neighbors, friends, or even community agencies, so that women may be contacted more easily.

Another clinic adjustment that seems to be needed is more flexibility in re-scheduling pregnant women, specially as they become heavier and sleepless nights cause them to desire additional rest in the early morning hours. Although there may be a conflict with early lunch hours (11:30 a.m.) for clinic personnel, it seems only fair that these women be given the opportunity to arrive for their check-ups or other procedures after 10:30 a.m.

Another conclusion that is the result of this study is that transportation is a problem because of linguistic and cultural barriers. In spite of the fact that many of these women understand enough English to interact with Anglo health
providers, there seems to be a mental block when the burdens of pregnancy and young children do not allow them to walk and, therefore, they must take a bus. Both the patients and the bus drivers need to realize their interdependence as patrons and providers of a community service. A few words in English will help the patients, and a few words of Spanish will certainly help the patients and allow the drivers to do a better job too.

**Recommendations**

1. This local investigation has shown the need for larger studies of similar childbearing populations. Research at BMSC should be initiated as soon as possible in order to validate findings of this limited study.

2. Baystate Medical Center should assist mothers with limited English ability to understand their financial billing system and Medicaid privileges or other financial help during pregnancy. This will be done immediately upon entering the system. The second prenatal care visit may be appropriate for educating mothers on financial matters, preferably using the expertise of WWU Social Service Department as advocates preferably a qualified bilingual/bicultural financial advisor.

3. That the Pioneer Transit Authority (PVTA) consider displaying signs and maps in Spanish. Under ideal circumstances the recommendation would be that bus drivers learn some Spanish as a service to the community.
4. That more cross cultural and multicultural education programs for health professionals be offered in the Greater Springfield area to sensitize health care providers to linguistic and cultural problems of patients/clients.

5. That the principal investigator share these findings with WWU's staff, discussing structural aspects of the clinic which may prevent some Puerto Rican women from keeping all scheduled appointments.

This study has convinced the principal investigator that applying the literature is not always conducive to the understanding or solution of local health problems, such as in Springfield, Massachusetts.

It has been a privilege to work with the women and the hospital.

As soon as the presentation to clinic staff and administration is scheduled, these recommendations will be prepared in more structured form, following the suggestions and expertise of the health care workers involved. A new calendar-card will be introduced at that time, hoping to distribute it among patients after some suggestions from the staff have been received.

The next chapter, Conclusions and Strategies, will deal with some recommendations and projects needed to improve the health care of Hispanics in general, and Puerto Ricans in particular. That will be followed by a Selected Bibliography and the Appendices.
CONCLUSIONS AND STRATEGIES

When this research was started, I was looking for strategies to improve communication between monolingual Hispanic patients/clients and Anglo providers that would improve the patient-provider interaction and foster quality care. I felt that my fellow Hispanics would benefit from the advantages of compliance/patient compliance defined as "following the health provider's instructions as to diet, exercise, rest, medications, schedule-keeping and other lifestyle changes." On the other hand, the Anglo health providers would become sensitized to the plight of mostly monolingual Hispanic individuals, caused by the barriers of culture, language, ethnicity, social class, education/literacy, acculturation, migration and the influence of the family.

What has emerged is the need for the education of health providers as a priority in health. Not only is it necessary to educate health providers on differences, but also on similarities with their Hispanic patients/clients. Provider education is crucial for quality care.

A review of the literature of patient compliance/non-compliance not only disclosed the universal nature of the problem, but it also showed that there is a commonality of factors between those affecting compliance and the ones identified as barriers to health of most patients, particularly Hispanics, and specially the Puerto Rican poor in Western Massachusetts.
Since the issue of compliance is well known in the health field, it seems the ideal vehicle for a holistic approach to health. It does not seem difficult to transfer some of this vast knowledge and research to in-service education for health care providers. The medical, nursing, and allied health professionals and paraprofessionals would then become sensitized to the needs of Hispanic patients in particular and all patients in general.

Through continuing education and training programs there is an opportunity to channel the vast research and literature on compliance/non-compliance to sensitize health care professionals. However, providers must not forget that Hispanics, the second largest minority in the United States—over twenty million people—are not a homogenized group. Intraethnic, intracultural variations and similarities must be considered in providing services to the various sub-groups. The need for a standardized definition of the term "Hispanic" among the various agencies and institutions in the United States is urgent. Otherwise, funds for programs and other benefits will continue to be diverted to other groups if a uniform definition for "Hispanic" is not adopted in the United States soon.

Another conclusion, quite simple but very important, is the need for a self-introspection on the part of health care providers. Only by becoming aware of ethnic and familial
backgrounds—-with an acceptance of the multicultural, multi-ethnic nature of most Americans and the contributions of the various groups—-will providers become effective in helping others. A suggested exercise is Suzuki's "Ethnic/Cultural Background Exercise," Appendix F of this work.

Language is a serious issue. This research has enthusiastically proposed that Spanish must be considered a public health tool. Bilingual people that are ill often feel confused, scared, and disoriented, even if they are competent in English. This happens even to those individuals proficient in a second language; they usually revert to their mother tongue. Being a Spanish monolingual is worse. It is hardly the time for health professionals in the United States to demand, "Let them learn English." Providers must learn some phrases and "medical imperatives" in the Spanish language, specially since many clinics show that 65% of their patients are Hispanics.

If providers do not have the time or the inclination to learn Spanish or to delve into the culture, then qualified bilingual bicultural interpreters or translators must be employed to attend the health needs of Hispanics. A "cultural broker" has actually been suggested by Hazel Weidman and other anthropologists. This individual would coordinate efforts for a better patient-provider interaction.

The English language must be considered a factor in upper mobility, while the Spanish language may become a barrier to
a better lifestyle among monolingual Hispanics. There is a need for more classes in English as a Second Language; true bilingual classes, dividing equal time for instruction in English and in Spanish. If bilingual education is to fulfill its role, it must act as a transitional tool to incorporate individuals into the mainstream. That doesn't mean that the Spanish language should be forgotten or the culture rejected. On the contrary. True bilingualism demands a proficiency in both languages. Language pride and loyalty should be fostered among Hispanics. However, knowledge of the English language is vital for survival and better opportunities in the United States. This is certainly an issue in health, greatly influenced by the factors of ethnicity and culture.

Providers are also reminded that the inclusion of the family in health matters is imperative. The Hispanic family must be considered at all times when health decisions are involved, since it is the source of traditions, beliefs and values affecting the health of its members.

The Spanish language also becomes a way of controlling siblings. Parents and grandparents may insist that children speak only Spanish at home. The culture of the school and of the home may clash. Providers must be aware of this problem and act as a bridge, not as a divider between parents and children.
The "parentified" child, described in Chapter IV must be discouraged from helping adults because of the problems with role reversals in Puerto Rican families. Qualified bilingual, bicultural translators and interpreters must be available in health settings to render this important service.

It is also important that providers become acquainted with the cultural traits of family names. In the Hispanic culture the "last name" is not the father's family name. The "last name" is the mother's maiden name and must not be used as the surname. Suggestions were given in pages 24 and 25 of this paper, in order to avoid confusion. Also, pride in the family name of Hispanics must be observed by learning the correct pronunciation of patients' family names. An effort should be made by Anglo Health providers in this respect.

The role of social class, is strongly stressed in this paper for health reasons. This factor must be included in health research, particularly in dealing with the members of the Hispanic poor in the United States. More commonalities will be found among the working Hispanic poor and Anglo health providers if the issue of social class is openly discussed. Indeed, class transcends color, nationality, ethnicity, and culture. There are few local research studies and health care data on Puerto Ricans in Western Massachusetts.

In contrast, there are more health studies and statistics concerning Mexican Americans, the largest Hispanic sub-group
in the United States. The resulting practice is to generalize and apply research findings and literature on Mexican Americans to Puerto Ricans in the Mainland.

The need for local studies and research on the health status of Puerto Ricans is of paramount importance. The applied part of this dissertation, the Descriptive Study, has demonstrated that generalizations found in the literature may be of help. However, the "realities" of local patients are different.

Care must be observed to avoid any bias in studies by carefully defining terms, operational definitions, selecting comparable populations, and stating objectives so as to permit comparisons among studies particularly on compliance.

More health programs are needed to attract and retain minorities in health. However, while special programs are being developed to recruit, train and retain Hispanic health care professionals, the available resource of qualified, sensitive Anglo health care professionals currently working in our communities must not be forgotten. In collaboration with this very important sector of the health community, culturally relevant health care programs are being planned and implemented. This appreciation for local Anglo expertise is exemplified by the fact that this dissertation has been dedicated to a committed Anglo health care professional, Miss Margaret Hogan. As the former Director of Nursing at
Wesson Women's Unit, Baystate Medical Center, Springfield, Massachusetts, she was very attuned and sympathetic to the Puerto Rican patients. The use of culturally relevant audiovisual materials prepared in local communities must be carefully monitored for levels of comprehension.

Linkages between health and educational organizations in Puerto Rico and Springfield must be seriously initiated and followed up, specially health education programs at the level of grammar school, and certainly before the fateful 9th grade. The education of young women affects the health of unborn generations.

It is up to Hispanic health professionals to contribute their time and expertise in conducting valid and reliable health research studies and programs based on the needs of local communities. No time should be wasted in developing and implementing sensitivity training programs for health care providers and educators in local communities. At the present time, there is a group of Hispanic health professionals meeting in Springfield since August 1984. The Western Massachusetts Hispanic Health Council--of which I am a member--is actively engaged in the improvement of health care delivery for the local Puerto Rican community, which is the largest Hispanic sub-group in this area. Intraethnic, intra-cultural variations and similarities among Hispanics are being emphasized, in order to provide critically needed health care programs for our local Hispanic population, significantly different from the Eastern Massachusetts region.
I am also developing programs in my place of work—Springfield Technical Community College—the largest community college in the Commonwealth, attracting qualified minorities in health careers. I will also continue teaching my "Cultural Spanish course, which is a blend of health, language, and culture (a good excuse for patient and provider education). Besides, as a result of this doctoral work, I have developed a new course entitled, "Multiethnic/ Multicultural USA." The objectives of this course are to sensitize allied health and nursing students to the influence of culture and ethnicity on health attitudes, beliefs and practices, with special emphasis on the backgrounds and familial histories of both students and future patients.

Furthermore, I will be actively pursuing my work in the community as an educator and a concerned Hispanic health professional. There are plans for a Cultural Spanish course to be taught by me next Fall to the Springfield public health nurses. Besides, during the month of May I will be sharing my findings and recommendations on the Descriptive Study with the health personnel and clinic staff at Wesson Women's Unit of Baystate Medical Center in Springfield.

Finally, my future plans include linkages with community agencies and the U Mass Medical School in Worcester. I hope to recommend and implement a multiethnic, multicultural, multilingual course for health care providers.
An open invitation is extended to fellow educators, researchers and health care workers to continue working for culturally relevant, valid, and practical research studies and programs for local Hispanic populations. The patient-provider interaction will then blossom, with a brighter future for the quality care of Hispanic patients—Puerto Rican in particular—and all patients in general.
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SAMPLE QUESTIONNAIRE FOR INTERVIEWING PREGNANT PUERTO RICAN
WOMEN AT WESSON WOMEN'S UNIT, BAYSTATE MEDICAL CENTER, IN
SPRINGFIELD, MASSACHUSETTS - (Telephone Interview)

Good morning/good afternoon. I am Mrs. Lourdes Delson, a doctoral candidate from the University of Massachusetts, School of Education. I would like to ask for your cooperation in gathering some data for my study on appointments that are not kept at the prenatal clinic at Wesson Women's and also appointments concerning laboratory or other procedures.

Your name will not appear in the study. You will remain anonymous. I would only like to know the reason/s why you have not come to the clinic for your scheduled appointment/s and any opinion/s you may have on your prenatal care. Your answers may help change some of the established methods of medical/health care and may make it easier for other women like you to keep clinic appointments. Your comments may also help nurses, doctors, and other health professionals to understand why Spanish-speaking women miss appointments, their needs and problems.

As I said before, your name will not appear at all in this study. If you want to contact me, you may call 781-7322 and ask for extension 3877. Otherwise, you may call Ms. Nancy Jones, a bilingual nurse who is working closely on this project, at 787-5536. Ms. Jones will also be able to give you some information on this project.

You do want to participate? Fine! Here are a few questions. Thanks again.

You do not want to participate? Well, one more question. Can you tell me some of the reasons why you attend Wesson Women's Hospital Unit? Thanks.

Participating Women Questionnaire:
1) Do you want to conduct this interview in a) English b) Spanish
2) Were you born in Puerto Rico or in the United States?
3) Do you consider yourself, or identify yourself, as a "Puerto Rican"? Explain.

(cont. p. 2)
(cont. p. 2 - Questionnaire - Code _______)

4) How long have you lived in Springfield? a) years ______ b) months ______

5) Who suggested that you get your pregnancy care at Wesson Women's?

6) Is that the same person who usually helps you make decisions about your health care?
   a) Yes ______ b) No ______

6A) If the answer is "No," Who is the person who usually helps you?

7) How far do you live from the clinic?

8) What kind of transportation do you generally use to come to the clinic for appointments?

9) Is it difficult for you to get transportation to come to the clinic? Explain, please.

10) How many children do you have at home?

11) What are their ages?

12) Is it difficult for you to make arrangements for child care when you have a clinic appointment? a) ________ Yes b) ________ No

12A) If "yes," explain, please.

13) What is your present occupation?

14) Do your hours of work conflict with clinic hours? How?

15) Can you tell me the reasons that prevented you from keeping your appointment on ________ date

16) What methods do you use to remember your appointments?

17) How many years of schooling do you have?
   a) 0 - 3 years  b) 3 - 6 years  c) 6 - 9 years  d) over

18) Place of education and years in each system
   a) Puerto Rico - ________ years  b) Springfield ________ years  c) Other ________
19) Can you a) read in Spanish? Yes ____ No____ A little____
b) understand what you read? Yes ____ No____ A little____
c) write in Spanish? Yes ____ No____ A little____
20) Can you a) read in English? Yes ____ No____ A little____
b) understand what you read? Yes ____ No____ A little____
c) write in English? Yes ____ No____ A little____

21) In which language do you prefer to read?
   a) English  b) Spanish  c) either language  d) cannot read either

22) If you have difficulty in understanding instructions, who do you ask for help or who helps you to explain instructions/directions?

23) Your impressions of the clinic will be very helpful to us in improving care for you and other patients. Please answer a few more questions. Thank you.

24) Do you use your appointment card to remind yourself of your coming appointments?  
   a) _____ Yes  b) _____ No

25) Did you understand why you had to come for an appointment on___________  
   (procedure/s)  
   for__________________________ date

26) Are the instructions given to you at the clinic usually clear?  
   a) Yes ____ b) ____ No  c) Sometimes _____ d) Never____

27) Can you easily read the printed materials given to you at the clinic?  
   a) Yes _____ b) No _____ c) Sometimes _____ d) Never____

28) Are you usually seen at the clinic by a male or female doctor?  
   a) male_____  b) female __________

29) Which do you prefer?  a) male _____ b) female _____ c) either one ______

30) How much time do you usually have to wait before seeing a doctor? Explain.

31) Would you say you are:  a) very satisfied  b) usually satisfied  
   c) somewhat satisfied  d) not satisfied with the care you are getting at  
   the clinic. Why?

32) How would you improve the present services at the clinic? Please give us some suggestions.

(cont. p. 4)
Only a few more questions.
Do you know something about foods or medicines that are cold or hot by nature which must not be eaten or taken during pregnancy or on hot or cold days when people are not feeling well? Are illnesses and temperatures related? Please explain.

If you know or have heard about this theory of hot and cold temperatures of foods and medications, can you elaborate further? Tell me briefly, please. Is there a member of your family who subscribes to this theory?

That is all for the moment. Next time you come to the clinic you will be able to sign a paper stating that you approved this interview. Thank you very much for your cooperation. Goodbye and good luck! ¡Adiós!

(Further comments)
Buenos días/buenas tardes. Soy la Sra. Lourdes Delson, educadora de la salud y candidata a un doctorado en Educación en la Universidad de Massachusetts. Quisiera pedirle su ayuda en contestar algunas preguntas relacionadas con un estudio que estoy haciendo sobre las razones por las cuales las clientes en el Hospital Wesson para Mujeres no cumplen con sus citas o con los tratamientos o procedimientos de laboratorio.

Su nombre no se mencionará en el estudio. Ud. permanecerá anónima. Sólo quiero preguntarle la razón o razones por las que no viene a la clínica cuando tiene cita/s y su opinión sobre el presente cuidado prenatal en la clínica, de servicios médicos. Su respuesta podrá ayudar a que se cambien métodos que se han seguido por un tiempo, y también quizás se haga más fácil que Ud. y otras mujeres como Ud. puedan cumplir con sus citas/turnos. Sus comentarios también facilitarán la mayor comprensión por parte de las enfermeras, médicos y otros profesionales de salud para que entiendan los motivos por los cuales las mujeres hispanas no cumplen con sus citas médicas, sus necesidades y problemas.


¿Quiere participar? ¡Excelente! Aquí van las preguntas. Mil gracias otra vez.

No quiere participar? Bueno una pregunta más. Puede Ud. darme unas cuantas razones por las que prefiere venir al Hospital Wesson? ¡Gracias!
Cuestionario para las Mujeres que Participen en el Estudio:

1) ¿Prefiere Ud. hacer esta entrevista en a) inglés b) español

2) ¿Dónde nación Ud.? a) En Puerto Rico o en los Estados Unidos

3) ¿Se considera Ud. puertorriqueña? Explíquese, por favor.

4) ¿Desde cuándo vive en Springfield? a) años b) meses c) 

5) ¿Quién le sugirió que utiliciera Ud. los servicios del Hospital Wesson para Mujeres durante su embarazo?

6) ¿Es esta la misma persona que generalmente la ayuda a hacer sus decisiones relativas a su salud?
   a) Sí b) No

6A) (Si la respuesta es "No," ¿Quién es la persona que generalmente la ayuda?

7) ¿A qué distancia vive Ud. de la clínica?

8) ¿Qué clase de transportación usa Ud. por lo general para venir a la clínica cuando tiene cita/turno?

9) ¿Le es difícil a Ud. conseguir transportación para venir a la clínica? Explíquese, por favor.

10) ¿Cuántos hijos viven con Ud.?

11) Cuáles son las edades de los chicos/auchachos?

12) ¿Le es difícil a Ud. hacer arreglos para que le cuiden los muchachos cuando Ud. tiene citas en la clínica?
   a) Sí b) No

12A (Si responde "Sí," Explique, por favor:

13) ¿Presentemente/en el momento, cuál es su ocupación?

14) ¿Hay un conflicto entre sus horas de trabajo y las de la clínica? Explíquese.
15) ¿Puede Ud. decirme cuál es o cuáles son la razón/razones que no le permitieron cumplir con su cita el ___________________________? (fecha)

16) ¿Qué métodos o arreglos tiene Ud. para recordar sus citas/tornos?

17) ¿Cuántos años ha ido Ud. a la escuela?
   a) 0 - 3 años  b) 3 - 6 años  c) 6 - años  d) más de 9 años ______

18) ¿En qué lugar fue a la escuela, y cuántos años?/hasta qué grado?
   a) Puerto Rico __________ año/ grado  b) Springfield __________ año/ grado
   c) Otro __________ año/ grado

19) ¿Puede Ud. a) leer en español?  S(____ No____ Poco ______)
b) entender lo que lee? c) escribir en español? _______ _______ _______

20) ¿Puede Ud. a) leer en inglés?  S(____ No____ Poco ______)
b) entender lo que lee? c) escribir en inglés? _______ _______ _______

21) ¿En qué idioma prefiere Ud. leer?
   a) Inglés  b) Español  c) cualquiera de los dos  d) no puedo leer ninguno

22) Si Ud. tiene problemas en comprender instrucciones, a quién acude Ud. o quién le explica a Ud. las instrucciones?

23) Sus impresiones de la clínica nos serán muy valiosas para mejorar nuestros servicios para Ud. y otras clientes. Por favor conteste unas cuantas preguntas más. Gracias.

24) ¿Usa Ud. su tarjeta de cita/torno para recordar su próxima visita a la clínica?
   a) _____ S( b) _____ No

25) ¿Entendió Ud. que teníase Ud. una cita para venir a la clínica el __________ para __________________________ para __________________________
   (procedimiento/s)

26) ¿Son/Claras las instrucciones que le dan en la clínica?
   a) S(____ b) No________ c) Algunas veces ______ d) Nunca ______

27) ¿Puede Ud. leer con facilidad el material impreso que le dan en la clínica?
   a) S(____ b) No ______ c) Algunas veces ______ d) Nunca ______
(p. 4 - Cuestionario)

28) ¿Quién la ve generalmente en la clínica, un doctor o una doctora?  
a) doctor  b) doctora

29) ¿A quién prefiere Ud.?  
a) doctor  b) doctora  c) cualquiera

30) ¿Cuánto tiempo tiene Ud. que esperar generalmente por lo general antes de que la vea un médico? Explíqueme, por favor.

31) ¿Diría Ud. que Ud. está a) muy satisfecha b) generalmente satisfecha  
c) un poco satisfecha d) no satisfecha con el cuidado que recibe en la clínica. ¿Por qué?

32) ¿Cómo mejoraría Ud. los servicios que actualmente recibe en la clínica? Hágale el favor de darme algunas ideas o sugerencias.

33) Unas cuantas preguntas más y terminamos. ¿Me puede Ud. decir qué clase de alimentos, bebidas y medicinas se pueden tomar o comer durante el embarazo—frías o calientes y por qué? Hacen sentir bien y son buenas para el nene? Cuénteme algo, por favor.

34) Si Ud. ha oído algo acerca de esta costumbre de alimentos o comidas y medicamentos que son frías o calientes por naturaleza, ¿puede Ud. contarme quién la enteró? ¿Hay algún miembro de la familia que sabe de eso?

35) Eso es todo por el momento. La próxima vez que Ud. vaya a la clínica le darán un papel que se llama "Carta de Consentimiento y Autorización" para que la firme confirmando que Ud. aprobó esta entrevista. Muchas gracias por su ayuda. Adiós y buena suerte.
A DESCRIPTIVE STUDY OF COMPLIANCE AMONG PREGNANT PUERTO RICAN WOMEN AT BAYSTATE MEDICAL CENTER IN SPRINGFIELD, MASSACHUSETTS

By Lourdes C. Delson

Purpose:

The purpose of this study is to investigate variables influencing compliance with prenatal and diagnostic test appointments among a sample of pregnant Puerto Rican women. Increasing health care providers' understanding of the non-compliant patient may assist in fostering favorable outcomes for minority women.

Target Population:

40 - 50 pregnant women of Puerto Rican origin attending prenatal clinic at Wesson Women's Unit, Baystate Medical Center.

Methodology:

Structured interview, preferably by telephone, will be conducted by the investigator using the attached questionnaire. If clients cannot be reached by telephone, interviewer will see patients at next regularly scheduled clinic appointment. Demographic information available in Continuing Care records will be utilized. Identification of target population will be made by the Supervisor of Ambulatory Ob/gyn clinic and/or her staff from daily appointment lists. Names of target population will be shared only with the investigator.

Protection of confidentiality:

Data collection forms (questionnaire) will not contain names nor will be coded to identify target population.

Variables to be investigated:

a) demographic
   1) age
   2) marital status
   3) trimester of entry
   4) length of residence in Springfield
   5) place of education
   6) years of study
   7) present occupation

b) structural
   1) accessibility of clinic
   2) distance between home and clinic
   3) means of transportation

   c) clinic environment
      1) waiting time during appointments
      2) sex of health provider
      3) clarity of instructions
      4) readability of instructional materials

(cont. p. 2)
c) personal characteristics
1. person in family responsible for health decisions
2. number of children patient is responsible for
3. ages of children
4. availability of child care
5. preferred language for reading materials (English/Spanish)
6. stated reasons for missing scheduled appointment/s
7. self-reminder methods used by patient

Questionnaire

Sample questionnaire attached. The interview will be conducted in English or in Spanish, according to the preference stated by the patient at the beginning of the telephone conversation.

Information on age, marital status and trimester of entry will be ascertained from the records.
APPENDIX C
BAYSTATE MEDICAL CENTER

Office of Medical Affairs
Memorandum

TO: Lourdes C. Delson, Nancy Jones
   Principal Investigator

FROM: Gerald A. Kerrigan, M.D.
   Vice President for Medical Affairs

SUBJECT: Protocol Number BMC84-7-1
   Protocol Title: A Descriptive Study of Compliance Among Pregnant Puerto Rican Women at Baystate Medical Center

DATE: July 31, 1984

The above protocol has been processed as follows:

COMMITTEE ON MEDICAL EDUCATION & RESEARCH -
Date July 12, 1984
Approved X
Disapproved
Tabled

COMMITTEE ON USE OF HUMAN SUBJECTS IN RESEARCH -
Date June 25, 1984
Approved X
Disapproved
Tabled

Please provide the following information:

N.B.
1. Patient consent forms should be placed and kept in the Medical Record.
2. The committees will ask you for a progress report of your study in 12 months.

SAX/cas
3/15/83
cc: Department Chairman
   Laurence E. Lundy, M.D.
COMPLIANCE STUDY: CONSENT FORM

Project Director: Nancy A. Jones, RN, MSN
Principal Investigator: Lourdes Delson, PhD Candidate, U. Ma.
Expected Duration of Study: 4 months (July 1984 through October 1984)
Title of Protocol: A DESCRIPTIVE STUDY OF COMPLIANCE AMONG PREGNANT PUERTO RICAN WOMEN AT BAYSTATE MEDICAL CENTER, SPRINGFIELD, MA.

I agree to participate in this study with the understanding that my name will never be used in any published results and that only the Investigator, Mrs. Lourdes Delson, will know my name. I also understand that the study does not involve any medical or experimental treatment and will not affect my prenatal or postnatal care in any way. I agree to answer the questions asked by Mrs. Delson but I reserve the right to refuse to answer any questions which I feel are a violation of my rights as a client of Baystate Medical Center.

I understand that this study will involve 50 women currently using Wesson Women's Unit of the Baystate Medical Center for prenatal care and that the study seeks to understand why appointments for medical care or procedures are not always kept by prenatal clients. The benefits of the study may be changes in the method of care delivery which will make it easier for me and others to keep appointments. Another benefit will be to increase the understanding of nurses, doctors and other professionals about the causes of missed appointments.

I understand that if I have any questions about the study, I may call either Nancy Jones, RN (787-5536) or Lourdes Delson ( ) and that I may request that my information not be used in this study any time before October 31, 1984.

Client signature
Witness:

263
Directora del Proyecto: Nancy Jones, Enfermera con Masters en Enfermería

Investigadora Principal: Lourdes C. Dalsin, Educadora de la Salud y Candidata al Doctorado en Educación Multicultural en la Universidad de Massachusetts (Amherst)

Duración Aproximada del Estudio: 4 meses (setiembre a diciembre de 1984)

Título del Proyecto: UN ESTUDIO DESCRIPTIVO DEL CUMPLIMIENTO DE INDICACIONES MÉDICAS ENTRE MUJERES PUERTORRIQUENAS EMBARAZADAS EN EL CENTRO MÉDICO BAYSTAD EN SPRINGFIELD, MASSACHUSETTS

Consejo participar en este estudio con la condición de que
nunca será revelado en cualquier resultado que se publique, y que sólo la
Investigadora, Sra. Lourdes Delson, sabrá mi nombre. También tengo enten-
dido de que en este estudio no habrá necesidad de ningún tratamiento médico
o experimental y que no afectará ni cuidado prenatal o postnatal en forma
alguna. Consiento responder las preguntas necesarias por la Sra. Delson, pero
se reserva el derecho de no responder aquellas preguntas que considera en
contra de mis derechos de cliente en el Centro Médico Baystate.

Tengo entendido de que este estudio contará con 50 mujeres puertorri-
quenas embarazadas que al presente están usando los servicios prenatales
del Hospital Wesson para Mujeres, parte del Centro Médico Baystate, y que
el estudio tiene por objeto indagar por qué las clientas en la clínica pre-
natal no cumplen con sus citas asignadas o con las indicaciones y prescri-
diaciones médicas. Los beneficios de este estudio quizás consistan en rea-
litar de técnicas que se sigan al momento para ofrecer servicios médicos,
lo que se hará más fácil para que yo y otras como yo puedan cumplir con
sus citas médicas. Otro beneficio será una mayor comprensión por parte de
las enfermeras, doctores, y otros profesionales sobre las causas que pre-
vienen cumplir con citas médicas asignadas.

También tengo entendido de que si tengo alguna pregunta sobre este
estudio podré llamar por teléfono a la Sra. Nancy Jones al número 747-5550,
ó a la Sra. Delson, al 741-7822, extensión 3877, y que podré solicitar en
cualquier momento antes del 31 de diciembre de 1984 que si información no sea
usada en este estudio.

Fecha

Firma de la Cliente

Testigo
Hola

Quiero pedir tu ayuda en un proyecto que estoy desarrollando con el Hospital Wesson Women's (para Mujeres) y la Universidad de Massachusetts. Se trata de averiguar las razones por las cuales muchas personas como tú no han cumplido o no pueden cumplir con sus citas o appointments médicos en el hospital. He preparado un cuestionario en inglés y en español para hacerles unas preguntas que nos parecen necesarias para mejorar nuestros servicios médicos, tanto para ti como para otras mujeres que quizás estén teniendo problemas con la transportación, cuidado de los muchachos, finanzas (falta de dinero), etc. Queremos realmente ayudarlas para que tanto Uds., nuestras pacientes, como sus bebés, estén sanos y contentos.

Me harás el favor de llamarme por teléfono al número 781-7822, anexo (extension) 3877 y preguntar por la señora LOURDES DELSON. Entonces yo te podré dar más detalles sobre este proyecto. Estaré en la oficina entre las 9 y las 4 y media de la tarde. Si no me encuentras me harás el favor de dejar un número de teléfono donde te puedo llamar, o si es mejor me puedes mandar una cartita indicándome cómo puedo comunicarme pronto contigo. La dirección es:

c/o STGC
1 Armory Sq.
Springfield, Mass.

01105

Te agradezco anticipadamente por tu ayuda.

Atentamente,

Lourdes C. de Delson
ETHNIC/CULTURAL BACKGROUND EXERCISE

developed by
Bob H. Suzuki

Purpose: This discussion exercise will attempt to meet the following basic objectives:

1. To help you get to know other people in the group on a more personal level.
2. To stimulate interest and curiosity in your own and others' ethnic/cultural backgrounds.
3. To help you delineate more clearly both the common and unique aspects of your own ethnic subculture.
4. To give you a better sense of the multicultural nature of American society and of the differing degrees to which different people have been assimilated.

Procedure: Each person in the group, in turn, should introduce him/herself, provide a little personal data (e.g., where you are from, present occupation, year and major in school, etc.), and then provide more detailed information on his/her ethnic/cultural background. You might wish to either address yourself to the questions listed below (which are only suggestions), or provide other information in which you think the group may be interested.

1. How far back can you trace your ancestry? When did your parents or ancestors come to this country? Where did they come from? Do you know why they came and under what circumstances?
2. Do you identify with any particular ethnic/cultural group? If so, which group? Did you grow up in an ethnic neighborhood? Were most of your family's friends members of a particular ethnic group?
3. Is your ethnic/cultural background an important influence in your life? For example, does it influence in any way the friends you choose, the foods you eat, the religion you practice, or your politics? Have you ever experienced discrimination because of your ethnic/cultural background?
4. To what degree do you feel you have been assimilated into the so-called "WASP" middle-class culture?

Members of the group should feel free to ask any additional questions related to the above questions.